Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month FRANK THOMAS DVORAK DECEMBER 4:05A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2530 Kensington Gardens unit 404 HOWARD CO. Ellicott CITY 5. Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Days 220-30-5002 77 1 ₹ M 2 □ F Director 2-18-1935 MARYLAND Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 end 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD. HOWARD CO. ELLICOTT CITY 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2530 KENSINGTON GARDENS UNIT 404 21043 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates id Mental Hygiene. marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SALESMAN REP. COMPUTER SYSTEM Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ MINNIE V. FOUTZ FRANK T. DVORAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Health if Item 27 other tra **SPOUSE** ELLICOTT CITY, MD JOANN DVORAK 2530 KENSINGTON GARDENS UNIT 404 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State = ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. GARDENS OF FAITH 12-14-2012 BALTIMORE, MD. 4 Donation 5 Other (Specify) 21. Signature of Full and S 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC 9705 BELAIR ROAD NOTTINGHAM, MD. 23a. Part 1 Enter the disease, or complications that consider, or heart failure. List only speciause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physiclan and I for use as the burlal-transi or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? After this certificate 1 Yes 1 Yes 2 No 2 12 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 TYes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide the Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number December 11 2012

State

Registrar

31. Date filed (Month, Day, Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rudolph V. DePaola OAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death EN time a None Social Security Numbe If Under 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** 1 XM 2 🗆 F Days Hours 07/26/1925 **Director** 220 12 7654 87 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No MD Ellicott City Howard 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 2810 Union Drive 21043 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces'

1 Yes 2 Completed by Black, White, etc. 1 Never Married 2 Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced Specify: White 1943-45 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Principal</u> Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Vincent DePaola Martha Eck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Louis G. DePaola/Son 2810 Union Drive Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cremation Center of MD 12-14-12 Hanover, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PSIS Sequentially list conditions, Examine If any, reading to minimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death g 🗍 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Récords, 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? After this certificate 2 <del>□</del> No 1 🗌 Yes 2 N Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 🗌 Yes 2 NO 1 Dipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 - Latural 5 Pending death. Accident 1 🗌 Yes 2 No after death Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier è 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D GERRELADL 21229 31. Date filed (Month, Day, Year) -Registrar

DHMH 17 Rev 7/2009

EPAL

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-08530 vin J. Donnelly		Please Type or Print in Black Indelible Ink. Ensure All C State of Maryland / Department of Health and Ment	opies Are Le al Hygiene	gible.	12 40003
,		For State Certificate of Death	R	eg. No.	3. Time of Death
Physicia		egistrar I. Decedent's Name (First, Middle,Last)	Date of Dea     Month	Day Year 10, 2012	1458 hrs
edical Examin	er	Kevin J. Donnelly		4c. County of De	
	4	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deltimore.	of Death	4c. County of Bo	
1	8	1505 Eastern Ave Baltimore	24Hrs R Date of B	idb(MM/DD/YYYY) 9.	Birthplace (State or Foreign
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under Months Days Hours	Min.		Country)
Director	-1	042-28-1022 1 XM 2 F 76 Yrs.	Dec	19, 1935	COnnecticut
	Ī	Usual Residence of Decedent			10d. Inside City Limits
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and show	5	MD Baltimore	— т	10g. Citizen of What C	Country?
ne Maryland or 28a-f show fred at once.	Director	10e. Street and Number 10f. Zip Code			
the N		1505 Eastern Avenue 21231	-i-2 / Specify Vos or N	USA	merican Indian, Black,
with ns 23	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Original In Yes, specify Cuban, Mexican	gin / (Specify residing i, Puerto Rican, etc.)	White, et	
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21215-0036 Nuld be filed within 7 Mental Hygiene. marked other than	e Be	19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Nur			
MD 2 nd 2 shou alth and M m 27 is r wumatic	욘	Riley Wilcox/friend 66 Henrietta Stre	et #2 Roch	ester, NY	14620
and 2 lealth tem 2 traur	1	20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - Cit	ty or Town, State
Ore		1 Burial 2 Cremation 3 Removal from State		1	
timen trant		4 Donation 5 X Other Specify: in state  21. Signature of Funeral Service Licenses  Ronald S. Wade Director  State Anatomy	ity 1 CEE	II Dolting	ara Street
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	5 V	Daltimore MD	21201		
Physician	-	233 Part I Enter the disease or complications that caused the death. Do not enter the mode of dying, such as	cardiac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and
Medical		failure. List only one cause on each line.			Death
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		Sequentially list conditions, b			
	ner	if any, leading to immediate Due to (or as a consequence of):			
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Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be exours after death.  The law pire of the physician is certificate has been signed by the attending physician retail Director: After this certificate has been signed by the attending physician present in by the intending physician property.	Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy	nia prograncy	23d. Date of do Month	elivery Day Year
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P.O. that the pred by detact	۾	Dementia, Atherosclerotic Cardiovascular Disease	1		Probably 4 V Unknown
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: Vid Physic r this	<u>P</u>	1 V Yes 2 No 1 1 28c Injury at W	ork? 28d Desc	ribe how injury occurre	d
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SiOn of the of death ctor:	,   ž	2 Accident Nov 10, 2012 1330 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building	, etc. 28f. Locati	on (Street and Numbe	r or Rural Route Number, City
ivis 10r A after Dire	ertification:	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse	or Tov 1505 Eas	vn, State) tern Ave, Baltimore	, MD
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif	_	29a Certifier . Deutsian Dhysician To the best of my knowledge, death occurred at the time, date and	place, and due to the	cause(s) and manner	as stated.
he Ho in 24 he Fu	2	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at the time,	date and place, and do	ue to the cause(s)
To t	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signe	ed (Month, Day, Year)
	-	O.C.M.E.		November	11, 2012
		30. Name and address of person who completed cause of death (Item 23a)			
		Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, B	Baltimore, MD 21	223	
	Stat	31. Date filed (Month, Day, Year)			
Reg		e 31. Date filed (Month, Day, Year) 2012 Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

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Deborah Gaynor D	1-	For Stete	State o	of Marylan		tment of	Health and	d Mental H		g. No. 201	2 1.000
Physician	/ 1	egistrar . Decedent's Name	e (First, Middle,Last)					-	2. Date of Deatl	h	3. Time of Death
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Funeral Director		. Social Security N	1	-	Age (In yrs. las	t birthday) Yrs	If Under 1 Year Months Days		n l	h(MM/DD/YYYY) 9. Bir Foreig 3 , 1953 Co	thplace (State ounk gn untry)
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MD and 2 sho saith and 2 sin 27 is	ļ.,	O.C.M.E			I 20h Pl	<u> </u>	V. Baltin		eet Balt	imore, MD	21223
imore Pages 1 ment of F. tant: If i	1	1 Burial 2 Donation 5	Cremation 3 X Other Specify:	in stat	State cre	ematory or ot	her place)		54.0	250. Essalish Sky di	Town, outc
Balt permit. Depart Import	-	21. Signature of Fu	peral Service Licens	90		22. N Sta Ba]	lame and Address te Anato timore,	of Facility my Boar MD 212	d₁ <sup>655 W</sup> .	Baltimore	Street
Physician /Medical		fallure. List on	ne disease, or compl ly one cause on eac	ch line.			he mode of dying, iovascular Dis		or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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5 W. S. D.	ĕ⊨	29b. Signature and	I title of certifier	and manner sta	teg.		29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
	-	30. Name and add	ress of person who	completed cause	of death (Item)	- M.	) O.C.	M.E. (	DOME	November 27, 2	012
		Theodore N	l. King, Jr., MD	. Assistan	t Medical E	xaminer	900 W. Baltir	nore Street,	Baltimore, MI	21223	
Stat Registra	~~	31. Date filed (Mon	th, Day, Year) FC 1 2 201	2 2	istrar's Signatur	1	1.1				
DHMH 17 Rev 1/200				- Justin	10.	ORIGINA	L				

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12-08577 Laurel S Dayton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 2 State of Maryland / Department of Health and Mental Hygiene

adiei o Dayloii		1- For State Crivial yiand 7 Department of Health 6 Certificate of Death Registrar	and Mental Hy	Reg.	No.	
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		4a. Facility Name (if not institution, give street and number)  4b. City, Town  Suburban Hospital  Bethesda	, or Location of Death		4c. County of Death  Montgomery	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1.	Year If Under 24Hrs.	8. Date of Birth (	(MM/DD/YYYY) 9. Birtl	
Director	-	218-66-8850 1 M 2 X F 57 Yrs. Months C	Days Hours Min.	Aug 31	, 1955 Foreign	Washington DC
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Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Mc Important: If Hem 27 is ma injury or other traumatic	Ì	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of crematory or other place)			20c. Location - City or	Town, State
Baltimore, permit. Pages I as Department of Hee Important: If tte		4 Donation 5 X Other Specify: in state				
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	Examiner	f any, leading to immediate cause. Enter Underlying Cause  (Disease or injury that initiated cause.				
cuted nd transit		events resulting in death) Last Due to (or as a consequence of): d.				
be exercian a	Medical	▼ UNPENDED	!-14-12 sm			
760, ficate be g physici the burn	¥	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	3		23d. Date of delivery	
Box 687  death certific  the attending p	Physician/	past 12 months? 2 Pretair death  14 Pregnant at time of death 5 Other (Specify)	3 Ectopic pregna	incy	Month D	lay Year
BO e deatl the att	hys	1 Yes 2 No 9 Unknown 9 Unknown				
cords, P.O. Box 68760, aw requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	<u>a</u>	Part il. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I.		acco use contribute to	_
rds requi	Completed			24a. Was an autopsy		topsy findings available ompletion of cause of
ecol he law ste has l	E E			perform	ed? death?	
ician: The certificate rector, page	BeC		lace of Death (Check o			
Vita hysici this ca	0	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	Other Nursing	g Home 5 R	esidence 6 Other	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start cleath.  To Director: After this certificate has been signed by led in by the fumeral director, page 2 should be detach.	tion: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c.	Injury at Work?  Yes 2 No	28d. Describe ho	w injury occurred	
Divisation At an after dar after de lied in by	Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, offi	ce building, etc.	28f. Location (Str or Town, Sta	eet and Number or Ru te)	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial — transi	Medical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opi and manner stated.				
E § E 8	¥.		cense number		29d. Date signed (Mor	nth, Day, Year)
		() (Stortaken)	.C.M.E.		November 13, 20	012
		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore St	reet, Baltimore, N	MD 21223		
St Regis	ate trar	31 Date filed (Month, Day, Year)  DEC 1 2 2012  Registrar's Signature				

12-09232 Earle Alexander		· · · · · · · · · · · · · · · · · · ·		ible.	1000
		1- For State Certificate of Death Registrar	Reg	No. 2016	4000
Physicia Medical Exami	-	1. Decedent's Name (First, Middle,Last)  Earle Alexander Daisley	2. Date of Death Month December 4	Day Year	3. Time of Death 1524 hrs
$\bigcirc$		4a. Facility Name (if not institution, give street and number)  5868 Stevens Forest Road #167  4b. City, Town, or Location of D  Columbia		4c. County of Death Howard	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 174-44-5073 1X M 2 F 85 Yrs. Months Days Hours	4Hrs. 8. Date of Birth Min. June 26	Foreig	hplace (State or n untryPanama
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
<b>≱</b> 111		MD Howard Columbia			1 Yes 2 No
he Maryland ior 28a-f show ified at ooce.	Director	10e. Street and Number 10f. Zip Code 5868 Stevens Forest Road #167 21045	10g	g. Citizen of What Cour USA	ntry?
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and I Hoge with a manual, or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at occ.	Funeral	11. Marital Status  1 Never Married 2 Married 7 Married 8 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt	? ( Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
s after iral",	by	3 Widowed 4 X Divorced If Yes, Give Year  1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kin	d of work done	Specify: b] 16b. Kind of Business/	ack
2 hour	sted	Elementary/Secondary (0-12) College (1-4 or 5+)		TOD. KIND OF BUSINESS/	ridustry
036 Aithin 7 ene. or thas	ompleted	12 0 clerk		sportswea	ır
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be Co	17. Father's Name (First, Middle, Last) unk 18.Mother's N	Name (First, Middle, Ma	aiden Surname)	unk
D 21 should I is man atic ev	ဥ	19a Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number 19b. Mailing Address)		•	, Zip Code)
mand 2 sho tealth and tem 27 is		Anselmo Daisley/son 806 Midwood Street  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		NY 11203 20c. Location - City or	Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)			
altin mit. P partme portan		4 Donation 5 Nother Specify: in state  21. Signature of Funeral Service Liversee 22. Name and Address of Facility			
		21. Signature of Funeral Service Liversee Parties of Pacility State Anatomy Bo Baltimore, MD 2	21201 <sup>655 W</sup>	Baltimore	
Physician /Medical examiner		23a. Parkl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	nac or respiratory arres	st, snock, or neart	Approximate Interva Between Onset and Death
Contract of the second	L	Sequentially list conditions, b.			
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
executed an and al - transit	ıl Examiner	events resulting in death) Last  Due to (or as a consequence of):  d.			
be executed in a number of the learning of the	dical	UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Theorem is after death. Ther this certificate has been signed by the attending physician and inpletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic p  4 Pregnant at time of death 5 Other (Specify) 9 Unknown	regnancy	23d. Date of deliver Month	y Day Year
D. B t the d by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	1. 23e. Did tob	pacco use contribute to	the cause of death?
, P.( res tha signed be det	d by		1 Yes	2 No 3 Pro	bably 4 🗹 Unknown
ecords ne law requi te has been	Completed		24a. Was a autops perform 1 Yes 2	prior to ned? death?	utopsy findings available completion of cause of
al R en: Th ertifica tor, pa	Be Co	25. Was case referred to medical 26.Place of Death (C		. The	2 110
of Vita ing Physici After this c	To B	1 103 2 110		Residence 6 🗸 Othe	r: Scene
n of ding Ph h. After t		27. Manner of Death 28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work? 1 Yes 2 N		ow injury occurred	
ivisior or Attendath after death Director:	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.		treet and Number or R	ural Route Number, City
Divis	ertit	3 Suicide 6 Could not be determined (Specify)	or Town, St	ate)	
DIV  To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one)  2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.			
To To con	Me	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	onth, Day, Year)
		(a C 1 1 1 1 1 1 ) O.C.M.E.		December 5, 20	12
		90 Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltim	ore MD 21222		
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1016, WID 21223	-	
Regis		d a 0010 /8 /8 /6 /6 /6			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ JoAnne T. Eitzen 10. 1125 a M 2012 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring ManorCare 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days (Month, Day, Year) Director 212-64-0333 1 M 2 TXF 60 Aug 20, 1952 Washington DC filed within 72 hours and tall Hygiene.

ad other then "neturel", or items 23e or 28e-f show en other then "neturel" or items 23e or 28e-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Prince George's Laurel MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20708 8612 Snowden Loop USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Travel Agent Travel Agency 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file end Mental F Is marked of ၉ Rocco Edward Talone Mary Cunningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8612 Snowden Loop Laurel, MD 20708 19a. Informant's Name/Relationship (Type, Print) ge 1 end 2 sint of Health e James C. Eitzen/husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Importent: If I eny Injury or o 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/11/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral St Going Hodges Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cholangiocarcinoma with metastasis Medical Due to (or as a consequence of): <sup>/</sup>Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of): end I-transit Exami The lew requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of): ettending physician e I for use es the buriel-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year signed by the et id be deteched fo 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cete has been sig ; pege 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an view autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 K No After this certificete I 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Designation Street Specify 2X□ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural injury 5 Pending ours after deeth. lerel Director: Aft filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours an To the Funerel Di completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 06-2011

Monica Immordino, CRNP 2501 Musgrove Road Silver Spring, MD 20904

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 1 2 2012

RN 114730

Dec 10,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2012 rear Dorothy Z. Enderiss 9:22 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Columbia Howard 10711 Shady Summer Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 220-20-2931 Director 1 🗆 M 2 👿 F 10-03-1927 85 Maryland items 23a or 28a-f show ler must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 XXYes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10711 Shady Summer Drive 21044 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Frederick Schneider Anna Elizabeth Happel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11101 Swansfield Road, Columbia, Maryland 21044 Zoe A. Irvin - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Meadowridge Mem Park 12-06-2012 Elkridge, Maryland 4 ☐ Dopation 5 ☐ Other (Specify) 21. Sign stu 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition 0415 Medical resulting in death) Due to (or as a consequence of) **Examiner** 20415 se ce Sequentially list conditions, if tarry, reading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last attending physician To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? igned by the atte be detached for Month Day Year 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has page 2 performed ☐ Yes 2 ☐ No filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Physician/ 8:36AM ero4 vovemb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner university of maryland medical Con Baltimor If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 218-64-2199 Director 1 XM 2 □ F 64 Oct 27, 1948 North Carolina permit. Pege 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene importent: If item 27 is marked other then "neture!", or items 23e or 28e-f show winjury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1217 W. Lafayette Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 K No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black If Yes, Give 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Booker T. Epps Bernice Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maggie Epps/aunt 1711 W. Baltimore Street Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Hother (Specify) in state Signatur of Principle License Lides, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myo cardial Physicianz da Medical resulting in death) Due to (or as a consequence of): Examiner namonro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform 1 Yes 2 No B 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

State

and addre

DEC 1

John Hegan 31. Date filed (Month, Bay, Year) 22 South Greene Street, BOHN MOTE

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

20/2

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2

			For State Registrar	State of IVI	aryland	•	irtment of t		Ivientai Hyg	eg. No.	12	40010
	Physicia		1. Decedent's Name (First, Middle, Las Dorothy Flanagan	t)					2. Date of Deat Month	er 8, 20	Year	3. Time of Death 10:33 a <sup>M</sup>
1	Medic Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, o	r Location of Deat		4c. County		10.00 a
			3701 Internationa	7			Silver			Monto		
	Funeral Director		5. Social Security Number 6. Security Number 138–16–0987 Usual Residence of Decedent	x 7. Age	e (In yrs. last 95	' birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		<sup>Year)</sup> 1917	Count	place (State or Foreign try) <b>Jersey</b>
	land show d at	tor	10a. State 10b. County			Town or Loc					10	0d. Inside City Limits
	28a-f	Director	MD Montgome	ry	Silv	er Sp						1 Yes 2 No
	s 23a or	Funeral D	10e. Street and Number 3701 Internationa	l Drive #5	515		10f. Zip Code 20906			USA	Vhat Coun	try?
9800	is filed within 72 hours after death with the Manyland that Hygiene.  I ship than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ※ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2  If Yes, Give Year or Dates.			/as Decedent of H Yes, specify Cuba ☐ Yes 2X No		pecify Yes or No- to Rican, etc.)	Blac	e - America k, White, e White	etc.
Maryland 21215-0036	iin 72 hou ie. han "nat e Medica	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)		5+)	(Give k life. DC	NOT use retired,	during most of wo	rking	16b. Kind of Bu		lustry
121	d with dygien ther ther ther ther ther ther ther ther	اما	17. Father's Name (First, Middle, Last)	2		Homem	aker	18 Mother's No	me (First, Middle, M	Own Hor		
lanc	be file  ental    rked o  ic eve	To	John Mulrenan						O'Connel		,	
Mary	ould d N ma		19a. Informant's Name/Relationship (Ty Diane Feldman/dau						ural Route Number, Derwood,			lode)
Baltimore,	permit. Page 1 and 2 sho Department of Health an Important: If item 27 is any injury or other trau once.		20a. Method of Disposition 1 ☐ Burial 2 汉 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	cen	netery, crem	sition (Name of eatory or other pla rney Cre	matory 1		20c. Location - Woodbi		
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service Licens	Fell	MO1 25	GC 51 Be	Name and Address ing Home verly L.	e Cremati Heckrot	on Servic	ce P.O. Clarks	. Box ville	784 MD 21029
П	nysician/	ii i	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused ne cause on each line a. Metasta	€.	Do not ente	r the mode of dyir	ng, such as cardia				Approximate Interval Between Onset and Death <b>months</b>
	Medical Examiner		resulting in death)	Due to (or as a	a consequer	nce of):						
N	sit d	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequer	nce of):						
	cate be executed physician and sthe burial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequer	nce of):						
092	te be e nysiciar he buri	edical		d								
3876	rtificat ling ph		IF FEMALE:	23c. If yes, outcome	of prognance							
. Box 68	hat the death certifica ed by the attending pl detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No g ☐ Unknown		2 Fetal d	death 3 🗌	Ectopic pregnan Other (specify)	су			te of delive inth	Day Year
ls, P.O.	uires that the signed by all he deta	ē	Part II. Other significant conditions of	ontributing to death b	ut not result	ting in the u	nderlying cause g	ven in Part I.				ne cause of death?
of Vital Records,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transi	Completed				_			24a. Was ar autops perforr	med?	Were autop prior to cor death? 1 \(\sum \) Yes	psy findings available mpletion of cause of
tal	ysician: The is certificate director, pag		25. Was case referred to medical examiner?	Hospital:				lace of Death (Che				
of Vi	Physi r this c eral dir	12	1 Yes 2 XNo 27. Manner of Death	1 ☐ Inpati	ent 2 EF	R/Outpatien 8b. Time of	t 3 DOA Oth	4 ☐ Nursing	Home 5 X Reside			)
	Attending or death. sctor: After by the fune	Certificate:	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day	y, Year)	injury	wor		200, 2000/150 110	Williamy Gooding		
Division	tal or Attending Pt rs after death. al Director; After th ed in by the funera		3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At home c. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Numbe n, State)	∍r or Rural	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	29a. Certifier (Check only one) 1  Certifying Physical Examination (Check only one) 2  Certifying Nursi	ner: On the basis of e	xamination a	and/or invest	igation, in my opin	on, death occurred	I at the time, date an	d place, and due	e to the cau	use(s) and manner stated.
	To the world to the common com		29b. Signature and title of certific	Roses	h		29c. Licens D9831			9d. Date signed		Jay, Year)
	15V		30. Name and address of person who can be arry N. Rosenbau					Kensinat	on, MD 20	0895		
	Sta Registr		31. Date filed (Month, Day, Year) <b>DEC 1</b> 2 2012	32. Registra								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. amend 18, per 1h, g934 12-12-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 09 2012 12:18P M FREEDMAN LEE Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) Examiner N/A BALTIMORE SINAI HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days Director 220-30-2936 1 □ M 2 🗓 F MD 12/20/1932 79 Usual Residence of Deced 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.

The man and Mental Hyglene, the man "natural", or items 23a or 28a-f show often transmic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21215 6901 DORSET PLACE 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) FOOD SERVICE COOKS ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ - NATHONSON-Nathanson FREEDMAN BESSIE LOUIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LITTLESTOWN PIKE, WESTMINSTER, MD 21158 HARRIS FREEDMAN/NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State MIKRO KODESH — BETH ISRAEL CONG. ₽ 1 X Burial 2 Cremation 3 Removal from State ± 5 permit. Page Department of Important: If any injury or once. 12/11/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Service Licensee 21. Signature of Fox 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis Immediate Cause (Final Physician/ CARDIOPULMONARY ARREST disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ESSENTIAL HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of: ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ANEMIA that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical HYPERLIPEMIA Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death a I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ RETARDED CITIZEN 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **HYPOTHYROIDISM** autonsy performed? 1 ☐ Yes 2 ☐ No ANDROID OBESITY 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 28b. Time of 28c. Injury at work? 27. Manner of Deet 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No м Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signatore and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State 2 2012 32. Registrar's Signature backs

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

Registrar

12-09156 Dolores Guild Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lores Guild		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death  Reg. No.  2 0 2 4 0 0 1 4												
Physicia	_	1. Decedent's Name (First, Middle	e,Last)								Date of Deat	h		ne of Death
edical Exami				Guild	l						Month December			152 hrs
		4a. Facility Name (if not institutio	n, give street and r	number)				Town, or L esda	ocation of	Death		4c. County of I Montgome		
		Suburban Hospital  5. Social Security Number	6. Sex	17 Ago (	(In ure Ir	ast birthday)		ler 1 Year	If Under	24Hre	8 Date of Bir	th(MM/DD/YYYY)		(State or
Funeral Director		260-38-5325	1 M 2XF		82		Mont		Hours	140	10/24/	Ì.	oreign Country)	
		Usual Residence of Decedent	1 M 2AF	1	02	Yrs					10/24/	1930	oodinay)	OA.
yu a		10a. State 10b. County		10	Oc. City,	Town or Locat	ion					<del></del>	10d. I	Inside City Limits
nd show	5	MD Mont	gomery		Poto	omac							1 X	Yes 2 No
1aryla 28a-f	Director	10e. Street and Number					10f. Zi	p Code			1	0g. Citizen of What	Country?	
a or Sa or		10025 Gable Ma	nor Cour	t			2	0854				USA		
h with	Funeral	11. Marital Status	12. Was Do	ecedent Ev	ver in U.			ent of Hisp ify Cuban,			cify Yes or No	14. Race ~ / White, e		dian, Black,
r deatl	Fun		1 Yes	2 7	No						, , , , , ,			
rs afte ural",	by	3 X Widowed 4 Div	orced If Yes, Give Y		leted)	16a. Deceder		No LOccupation	200000000000000000000000000000000000000	ind of wor	rk done	Specify: 16b. Kind of Busir	white	
2 hour	Completed	Elementary/Secondary (0-12)	during most of working life, DO NOT use retired)											
D36 thin 7 than fedica	현		2			Homem	aker					Own Hor	ne	
5-0 led wi Hygien		17. Father's Name (First, Middle,	Last)					18	8.Mother's	Name (F	irst, Middle, I	Maiden Surname)		
21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Ray Langham									Hicks			
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 13a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (Type, Print)  Mark Guild / son  19b. Mailing Address (Street and Number-or Rural Route Number, City or Town, State, Zip Code)  6903 Crail Drive Bethesda, MD 20817												
and 2 ealth cen 2 traum		Mark Gulld / S 20a. Method of Disposition	on		20b. F	Place of Dispos					Date	20c. Location - C		State
Baltimore, Department of Hea Important: If iter		I — <u> </u>	n 3 Removal	from State	e c	crematory or ot	her place	∍)		ъ.	7 2012	D - +1 1-	M	
t. Pag rtment			Donation 5 Other Specify: Potomac U.M.Cemetery Dec.7,2012 Bethesda, M. Signatur of Furry Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc.											
Bal Permi Depar Impo		21. Signatur Bi Fu di Service	Licensee	_		55	55 Tw	in Kno	11s Ro	oad (	zke rune Columbia	rai nomes,i , Maryland	nc. 21045	
Physician		23a. Part I. Enter the disease, or		caused th	ne death.	. Do not enter t	he mode	of dying, s	such as ca	rdiac or re	espiratory arr	est, shock, or heart		proximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	1-1	oral Hen	norrha	ige							Bei	tween Onset and Death
xaminer		or condition resulting in death)	Due to (or as											
	-	Sequentially list conditions, if any, leading to immediate	b. Hypertens Due to (or as				ase							
	nine	cause. Enter Underlying Cause (Disease or injury that initiated		a conseq	derice o	1).								
isit	Examiner	events resulting in death) Last	Due to (or as	a conseq	uence o	rf):								
ox 68760, ath certificate be executed attending physician and or use as the burial - transit		UNPENDED	d								_		_	
50, te be er ysician burial	ledical			s, outcome	of pred							23d. Date of de	Niver	
Box 6876( death certificate the attending physelecture as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ha	s, outcome e birth	) OI brear		etal death	з [	Ectopic	pregnanc	су	Month 23d. Date of de	Day	Year
ox 6 ath cer attendi	sicia			gnant et tir	me of de	eath 5 0	ther (Sp	ecify)						
he dez	Phy	Part II. Other significant condit	9 011	known	hut not r	esulting in the	underlyir	n cause ni	ven in Par	+1	23e Did to	obacco use contribu	ite to the ca	use of death?
, P.O. Box 6 res that the death cer signed by the attendi be detached for use.	á	Diabetes Mellitus		, to death t	Jacobott	osaking in the t	and only ii	ig caase gi	von mir a			2 <b>√</b> No 3		
ords, w require as been sig	Completed										24a. Was			findings available
cords law requi	튵		<u> </u>									rm <u>ed</u> ? de	ath?	etion of cause of
tal Rection: The certificate ector, page		25.11						00 DI	- f P) 41- //	01	1 Yes	2 No 1	Yes	2 No
Division of Vital Records, the Hospital or Attending Physician: The law requirint 24 hours after death the Kimeral Director: After this certificate has been supletely filled in by the funeral director, page 2 should b	å	25. Was case referred to medica examiner?	Hospital:	l Innation	2 🗸	ER/Outpatient	3		of Death (		Home 5	Residence 6	Other:	
of Viting Physical After this uneral direction	은	1 Yes 2 No 27. Manner of Death	28a. Da	te of Injury	,	28b. Time of			at Work?			how injury occurred		
ion of tending Pheath.	흲	1 Natural 5 Pen	ding	nth, Day Yea	ır)			1 Y	es 2 🗌	No				
/iSic r Atte ter des irecto n by t	<u> </u>		estigation 28e. Pl	ace of Inju	ıry - At h	ome, farm, stre	et, facto	ry, office bu	uilding, etc	. 2		Street and Number	or Rural Ro	oute Number, City
Division  Hospital or Attend 24 hours after death. Funeral Director: stely filled in by the f	Certification:	Suicide or Town, State)  4 Homicide (Specify)												
24 ho 24 ho Fune		(Onech billy	hysician: To the b			-			-					
Divisi To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	A 2	aminer: On the bas and manne		ination a	ind/or investiga				curred at t	the time, date			
	Σ	29b. Signature and title of certific	er	)			2	9c. License				29d. Date signed		ay, Year)
		( Analys	hearts)					O.C.N	/l. ⊨ .			December 3	, 2012	
		30. Name and address of person Laron Locke MD. A	n who completed ca Assistant Medic		,		altimoi	e Street	Raltim	ore Mi	D 21223			
c				Registrar's				- Oliect	, Daitiiii	iore, ivii	D 2 1223		-	
Penis	tate		2012 2	to gioti ai	A	ure fact	2							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per PHY C948 2/05/2014 JH State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 12/06/2012 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Da Month Evelyn G. Gartrell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimere Hospital 8. Date of Birth Anai of Baltimore If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. (Month, Day, Year) Director 213-36-4034 1 M 2 X F 72 Jan. 1, 1940 Maryland Usual Residence of Deced in then "neturei", or items 23e or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 622 Charraway Road 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 If Yes, Give Year or Dates Specify:White 1 ☐ Yes 2 🔀 No Specify. 3 HWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o William A. Boone, Sr. Ruth Swift 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2412 Zion Road; Baltimore, MD 21227 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 end 2 sh Department of Health ar Importent: If item 27 is eny injury or other treu Patricia J. Gartrell-Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place)
Lake View Mem. Park 12/13/12 Sykesville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute myo Cardial Infanction Physician/ disease or condition Medical resulting in death) I will Due to or as a consequence of Examiner Sequentially list conditions, sequentially list conditions, if any teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine End Stage Hospital or Attending Physician: The lew requires thet the death certificate be executed renal ettending physician end for use as the burial-tran Due to (or as a consequence of): Physician/Medical Disseminated Intriviocular Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the e completely filled in by the funeral director. page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease on Hemodralys End Stree renal 1 Yes 2 No 3 Probably 4 Unknown Brabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No mellitus 24a. Was an autopsy performed Upper tension 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) UUU Dec 6, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rupinder MD Sinai 31. Date filed (Month, Day, Year)

NEC 1 2 2012

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20b, per fh, g934 12-12-12 sm. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death SECSUBSL Day Zoll Physician/ GLASSMAN 11:40PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ENVOY OF PIKESVILLE PIKESVILLE If Under 1 Year If Under Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpi-Country) MD Funeral 1 🗆 M 2 🗓 F Davs Hours (Month Day Year) 12 100Yrs Director 215-09-0065 Usual Residence of Decedent show 10a. State 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at death with the Maryland Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21208 16 OLD COURT ROAD USA ral", or items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced WHITE ed other than "natur event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SURVEY TAKER RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I tem 27 is marked o ဂ COHEN BESSIE PARTNER ABRAHAM item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEAL GLASSMAN / SON 5139 WESTBARD AVENUE, BETHESDA, MD 20816 20b. Place of Disposition (Name of Bungary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō Important; If it any injury or o X Burial 2 Cremation 3 Removal from State -ISRAEL CONG. 12/11/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Live 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -ailure 10 Physiciani disease or condition resulting in death) Medical e to (or as a consequence of) **Examiner** SHENTO Sequentially list conditions Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Be Completed by Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month 5 Other (specify) 1 Ves 2 Unknown the signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BINGNESS 1 Yes 2 No 3 Probably 4 Unknown phods 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an page 2 autoosy performe 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 \( \text{Yes} 28d. Describe how injury occurred After 1 Natural 5 Pending iniury s after dec. seral Director: Ab d filled in by the 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) CHI R088852 DSC91189210 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY MARY/AND 21802

State Registrar KATTHUSSN

31. Date filed (Month, Day, Year)

P.O. BOX 2613

2MOND

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ R. Holloman Barbara December 9 2012 4:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring 10314 Ridgemoor Drive If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day Day, **Director** 217-46-8996 1 M 2 XF 66 1946 Washington, DC 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20901 USA 10314 Ridgemoor Drive 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Yes, Give Specify: White 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Assistant Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jean Maebelle Smith Edward Reinmuth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10314 Ridgemoor Drive Silver Spring, MD 20901 William H. Holloman, Jr/husband 1 and 2 s of Health i injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 12/12/12 Woodbine, MD 21. Signature of Funeral Service Lic Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 Xo Day Pregnant at time of death signed by the a q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2x No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy performe 2 🗌 No Yes 2 X No 1 Tyes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 6 Hospital Other: 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pendina work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident
3 Suicide
4 Homicide M Investigation

Box 68760 P.O. Records, the funeral director, Division of Vital To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it filled n by

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifie

Cheryl A. Aylesworth, M.D. 2730 University Blvd W #400 Wheaton, MD 20902 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

DHMH 17 Rev 06-2011

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

D54378

2 Medical Examiner: On the basis of examination and/or investigation, in this option, useful occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

December 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ember Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner more 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 069-52-0908 Director 1 M 2 X F 74 Apr 13, 1938 Pakistan permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene, Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director 1 ☐ Yes 2√☐ No Forest Hills Gardens Queens 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 117-19 Union Turnbike 11375 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Abdullah Muhamad Zanib Bibi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abdul Hamid (spouse) 117-19 Union Turnpike, Forest Hills Gardens, NY 11375 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Memorial Park 12/13/12 Coram, NY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician pertensive disease or condition resulting in death) Medical (or as a consequence of): <sup>\*</sup>Examiner pronary artery Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Diabetes use as the burlal-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No page 2 should be detached for Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 Be B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner 1 eath 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred Watural iniury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the F only one) 29b. Signature and title of certifier barrie M. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD.2128 DHAVAL DESAL 31. Date filed (Month, Day, Year)
DEC 1 2 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17em 19b per fh g934 12-12-12 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 · DO AM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death County of Death 4b. City Examiner SIMS DIPICE If Under 1 Year If Under Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Country) 247.48.4760 Director 1 □ M 2 \ F 84 1928 103 : if item 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State be filed within 72 hours after death with the Maryland Director Randalistown MD Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21133 USA 3905 Rayton Boad 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Countil if Health and Mental Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) schools Teacher 12th grade 6 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Ernest W. Fairwell Thelma. Watson Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Sister) 256 Green Sen Horth Bettyo Gale Bellamy Rd. North Loris, SC. 29569 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 s
Department of F
Important: If ite
eny Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 17/2012 Loris, SC Solid Grove Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Mcility Vaugna C. Greene Funcial Services 872 Handall stown MD 21133 lau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 25. Was case referred to medical 26. Place of Death (Check only one) nowheat Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury PS Natural 5  $\square$  Pending work?
1 Yes 2 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af ☐ Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, 30. Name and address of person who completed cause of death Item 23a) (Type, Print) etty U 31. Date filed (Month, Day Year, 32. Regi State DEC 12 Registrar

AMEND PI LINE C PER MD G934 12/12/12 TRT
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year D'Angelo Harris 1318 20 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center university of Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 493-54-6815 Director 1 🔀 M 2 🗆 F 61 Mississippi 06/23/1951 Usual Residence of Deced show 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 28a-f Maryland Baltimore 1 X Yes 2 No 10e. Street and Number ms 23a or 2 must be no 10f. Zin Code 10g. Citizen of What Country? Completed by Funeral 2555 Harlem Avenue U.S.A. 21216 items permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🔀 No Specify: Black 3 Widowed 4 X Divorced Year or Dates Medical Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) f Health and Mental Hygiene. item 27 is marked other than ' other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Technician Computer Sales Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Lane, Sr. Lucinda Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2415 Farnham Court Florissanr, Missouri 63033 Darius Cobb 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-03-12 Oakdale Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Lemay, Missouri Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 23a. Part 1. Enter the disease, or cognications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6009 Harford Road Baltimore, Maryland 21214 Interval Between Immediate Cause (Final Onset and Death Physician/ failure disease or condition resulting in death) Liver 5 years Medical Due to (or as a consequence of Examiner Pailure 5 years Henal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ASCENDING AORTIC DISSECTION attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the at 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Yes , 2 🗌 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medica **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 182 1388976 nichelle Kerns, MD 10/20/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street Baltimore, MD 2120 Michelle Kerns 31. Date filed (Month, Day, Year, 32. Registrar's Sign ture State NOV 1 5 2012 Registrar

34+6+

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 425 PM Physician/ SY. 2012 Kenneth Aaron 12 Ò Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1332 TANEY AVE APT 202 FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 214-58-5127 Hours Director BALT. MA 60 NOV. 23.1952 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director FRODERICK MD FREDERICK Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 1332 TANEY AVE APT 21702 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

Yes 2 No
If Yes, Give Black, White, etc. or. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 BLACK 1 Yes 2. No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. WELLS FARGO Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the YRS UNDERWRITER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SR. HERMAN HELEN Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1332 TANEY AVE APT 202 FREDERICK MD ZITOZ HILL (WIFE) KATRINA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2/ Cremation 3 ☐ Removal from State DEC. 8 2012 SMITHSBURG MD. SMITHSBURG CREM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CARY L. ROLLINS FUN, Itom C 21. Signature of Funeral Service Licensee Collin Sums. 110 WOST SOUTH ST FREDERICK MO 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if ary, leading to in modification. Enter Underlying Cause (Disease or injury burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) signed by the and to be detached for 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Matural 5 Pending injury work? 1 Yes 2 No ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #109 Thomas Johnson MO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ Boower 0% 3:30 AM M 0500 Medical 4b. О ty, 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 21629 roline 410 Colonia Denton M pros ear If Under 24 Hrs. ays Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 11-28-1909 Pennsylvania 577-12-8836 03 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notice." 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 🗌 Yes 2 💢 No University Park Prince George's MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20782 USA 6507 41st Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2x No Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) construction supply warehouseman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida May Bosworth မ Bethel Bruce Hosey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2519 Adams Landing Road Denton, MD 21629 DEnnis Hosey/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Euneral S. Nice Licens <sup>22. Name and Address of Facility</sup> State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 222 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Due to (or as a consequence of) neumanon disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes is certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: ✓ Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13 D0053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3683 Chaptonk Rd Preston MD 21655

Registrar DHMH 17 Rev 7/2009

State

melinde 31. Date filed (Month, Day, Year)

**DEC 12** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Certifit	cate of Death	Rec	ı. No.	
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death
edical Exami	ner	Tolly may doll		December	1, 2012	1352 hrs
		Sacility Name (if not institution, give street and number)     3028 E. Baltimore Street Apt. B	4b. City, Town, or Location of Deat Baltimore	th	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		s 8 Date of Birth	(MM/DD/YYYY) 9. Birti	nolace (State or
Director		213_80_8002 🔻 —	Months Days Hours Mi	n.	Foreign	1
		Usual Residence of Decedent	Yrs.	Mar 19	1962	mtry)Maryland
any			vn or Location			10d. Inside City Limits
p wo y	_	MD B.	altimore			1 Yes 2 No
aryłar 8a-f s	5	10e. Street and Number	10f. Zip Code	100	J. Citizen of What Coun	try?
he M. I or 2 iffed	Director	3028 E. Baltimore Street #B	21224		USA	
with 23, 12 23,		11. Marital Status unk 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( §		14. Race - Americ	can Indian, Black,
death r iten	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	White, etc.	
after (	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify: whi	te
ours a			Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re		16b. Kind of Business/Ir	ndustry unk
6 172 h	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	urea)		
within year.	Completed	9 0	laborer			
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 77 is marked other than "natural", natic event, the Medical Examiner.		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	,	
212 Ild be Ments mark	To Be	William James Hayden  19a. Informant's Name/Relationship (Type, Print)	_indblom er, City or Town, State,	Zin Code\		
MD 3	-	Robert Hayden/brother	3028 E. Baltimore St			21224
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Menta Hygiene attent of Health and Menta Hygiene. Attent of Health and Menta Hygiene attent of Hole 27 is marked other than "matural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	ý n	20a. Method of Disposition 20b. Place	e of Disposition (Name of cemetery,		20c. Location - City or	
ages ant of a		T Burial 2 Oremansi 5 Tremoval nom State	natory or other place)			
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tri		4 X Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	22. Name and Address of Facility			
ii ii ji ji ji ji		21. Signature of Funeral Service Licensee Ronald, S. Wade, Director	22. Name and Address of Facility State Anatomy Boar			Street
Physician		23a. Part Enter the disease, or complications that caused the death. Do failur List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a Diabetic Ketoaci	dosis			Between Onset and Death
- Adminier		or condition resulting in death)  Due to (or as a consequence of):				
-	-	Sequentially list conditions, b				
	nine	cause. Enter Underlying Cause				
st. G	Examiner	(Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):				
760, cate be executed physician and he burial - transit		d	,27,per me,g935 1-28	12 cm		
760, cate be execut physician and he burial - tra	Medical					
	-	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth	cy 2 Fetal death 3 Ectopic pregr	ancy	23d. Date of delivery Month D	ay Year
Box 68  e death certif  the attending  ed for use as	icia	past 12 months?  4 Pregnant at time of death	5 Other (Specify)		l moner b	ay rou
Box 687 he death certifiantly the attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown				
that the detach	by P		ting in the underlying cause given in Part I.	- 11	acco use contribute to t	
S, F uires an sign	ed	Coacaine Use			2 No 3 Prob	
ord Iw reg as bee	plet			24a. Was ar autopsy	prior to co	opsy findings available ompletion of cause of
Rec The la	Completed			perform 1 Yes 2	ed? death? No 1 ✓ Yes	2 No
inn:	Be	25. Was case referred to medical examiner?	26.Place of Death (Check			
n of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by lineral director, page 2 should be detach	70	1 Yes 2 No		ing Home 5 R	esidence 6 🗸 Other:	Scene
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	ü	1 X Notural (Month, Day, Year)	b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
SiO Atten death cctor:	cati	2 Accident Investigation	1 Yes 2 No			
Divi	Certification:	Suicide Could not be determined (Specific)	farm, street, factory, office building, etc.	or Town, Sta	eet and Number or Rur te)	al Route Number, City
lospita   hour   hour   unera		29a. Certifier				
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Functal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the complete of the property of the property of the funeral director, page 2 should be detached for use as the page 2 should be detached for use as the funeral director, page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2.	Medical	one)  2 Medical Examiner: On the basis of examination and/o				
To wit	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th. Day. Year)
		anetz	O.C.M.E.	1	December 2, 201	. ,
		30. Name and address of person who completed cause of death (Item 23a	))			
		Ana Rubio M.D., Ph. D. Assistant Medical Examin	•	more, MD 212	23	
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	4.41			
Regist	trar	DEC 1 2 2012 Jeneur B. 14	parkel			

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month 54 M Marris Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death bhrs 1 14 5. Social Security Number unk 8. Date of Birth (Month, Day, Year) 7. Åge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Min. unk Director 1 🔀 M 2 🗆 F Dec 12, 1940 71 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland al Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21231 USA 1017 E. Baltimore Street unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc unk ģ 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: black 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation unk unk 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk . Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot unk. 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Hospital 1800 Orleans Street Baltimore, MD 21287 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 📉 Other (Specify) in state 21. Signature of Funeral Service Licersee Ronald Swinder, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Virector Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Abnormal disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a conseduence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Ö signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 N To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ecember 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) for the Homelest, 421 tallsway, Baltmore, MD 21202 vanasaman 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2012 Henry Clay Hackett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice at Salisbur The Lake Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Day, Year) Min. Director 175-28-4339 Usual Residence of Dece 1 🕅 M 2 🗆 F 75 1936 17, Delaware Pege 1 end 2 should be filed within 72 hours after death with the Marylend ment of Heelth end Mental Hyglene.
sent: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Madical Eventinar must be notified at 10a, State 10b. Count 10c. City, Town or Location Director MD 1 Yes 2 No Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27115 S. Tourmaline Drive 21830 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 salesman computers Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles M. Hackett Dorothy Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Hackett/son Backbone Road Princess Anne, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Important: It any injury or 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Serge Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Mir@ctor in Baltimore. MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONINS Immediate Cause (Final Physician disease or condition resulting in death) Medical sequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consuluence of To the Hospital or Attending Physicien: The lew requires thet the deeth certificete be executed within 24 hours after death.

To the Funeral Director: After this certificete hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 🗌 No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No မှု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number # 68413 e of death (Item 23a) (Type, Print) 3 Salisbury, 170 21802
egistrar's Signature unacol Sheekan D.O. Funavoli Sheehan 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death I. Dece dent's Name (First, Middle, Last) 3. Time of Death chinsun 0538 AM Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rock Glen Nursing Home more 0 If Under 24 Hrs. 8. Date of Birth Hours Min. Month Cay Social Security Number 7. Age (In yrs. last birthday) 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Months 30 7090 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21229 morley St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married 2 No þ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) School ustodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည IINV JOK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45 morley Balto MD 21229 Alberta Williams - daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 12-15-12 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature Funeral Service Service 22. Name and Address of Facility P. march FH 240 Fredhilten Pass Boltomo 21229 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line. Interval Between On t and Death Immediate Cause (Final disease or condition resulting in death) Physician/ VPa Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of. attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Day Year Pregnant at time of death Yes been signed by the should be detached 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed' 1 ☐ Yes 2 ☐ No After this certificate Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 2 No ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29d. Date signed (Month, 010 Name and address of person who completed cause of death (tem 23a) (Type, Print) 10 North Rock Wen Ruad Homare 1spelmeier

State Registrar 31. Date filed (Month, Day, Year)

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of Ma	aryland / [		rtment of H ificate of D		1ental Hy	2	012	1.0025			
			Registrar  1. Decedent's Name (First, Middle,	Last)		Cert	incate or D	Catii	2. Date of De			3. Time of Death			
	Physicia Medic		Paul Luther J	ohnson					Month Decer	nber 5	, 2012	9:00 P M			
~- )	Examin		4a. Facility Name (if not institution,				4b. City, Town, or				inty of Death				
mare!	Company		10654 Montrose 5. Social Security Number		(In yrs. last birt	hdav)	Bethesda If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		gomery 9. Births	place (State or Foreign			
	Funeral Director		295-38-2286	1 🔀 M 2 🗆 F			Months Days	Hours Min.	June 10	y, Year) 0, 1944	Coun	otry)			
	ld now	١	Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	n or Loca	ation					I0d. Inside City Limits			
	larylar 3a-fst ified	Director	Montas	merv	Bethes							1 🗆 Yes 2 😾 No			
	the N		10e. Street and Number				10f. Zip Code				of What Cour	ntry?			
	th with ms 23s	Funeral		10654 Montrose Avenue #202 20814 USA  1 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-											
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  it health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show either traumatic event, the Medical Examiner must be notified at	Completed by Fu	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married 2 ☑ Marries</li> <li>3 ☐ Widowed 4 ☐ Divorced</li> </ul>	Race - Americ Black, White, cify: Whit	etc.										
2-0	hour "natur	plete	15. Decedent (Specify only highes	of Business In											
121	thin 72 ene. than the Me	Som	Elementary/Seconday (0-12)	ic Heal	lth										
<u>0</u>	iled wi I Hygik other rent, t	Be	17. Father's Name (First, Middle, La	ame)											
ylar	ld be f Menta arked atic ev	2	Gerald Edwin Jo												
, Maryland 21215-0036	nd 2 shou saith and n 27 is m er traum		19a. Informant's Name/Relationshi Terryl Lynn Nel		19b	o. Mailing <b>0654</b>	Address (Street a	nd Number or Rura <b>Avenue</b>	#202 B	ethesd	n, State, Zip C a , MD 2	20814			
Baltimore,	permit. Page 1 an Department of He Important: If iten any injury or oth once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (Sp		cemete	rv. crema	tion (Name of atory or other place rney Cre	matory 12	Date 2/08/12		on - City or To ine, M				
Balt	permit. Departr Import. any inji		21. Signus re of Funeral Service Li	Le Other	MO1251	22. GO Be	Name and Addres ing Home verly L.	s of Facility Crematic Heckrott	n Serv	ice P	.O. Boz	x 784 e, MD 21029			
			23a. Part 1. Enter the disease, or on shock, or heart failure. List or		the death. Do r							Approximate Interval Between			
- 4	nystotan/		Immediate Cause (Final disease or condition resulting in death)	_ a Malignar	nt Neop	lasm	of Rect	osignoid	Juncti	on		Onset and Death			
	Medical Examiner		resulting in death)				of Live								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	i consequence										
	cuted and transit	Examiner	Cause (Disease or linjury that initiated events	C. — Duo to (or on o	- Dongoguonoo	ofl:		<u> </u>							
	ate be executed ohysician and the burial-transit	dical E	resulting in death) Last	Due to (or as a	a consequence	Oi).									
3760	ficate   g phys	/ledi		d			-								
Box 68	leath certine e attendine d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2  Fetal deatl		Ectopic pregnancy Other (specify)	у		23d	. Date of deliv Month	ery Day Year			
о. П	of the call by the stacher	Phys	9 Unknown  Part II. Other significant condition		ut not regulting	in the un	derlying cause giv	en in Part I	220 Did	tobacco use o	contribute to t	he cause of death?			
S, P.	uires tha n signed ald be d	ed by	Tartin Other digililloant donated	is continuing to doute			aciny mig according					bably 4 Unknown			
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attended.  Within 24 hours attended the continuate has been signed by the attending physician and to the Funeral Director. Atter this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed									4b. Were auto prior to co death? 1 \(\sum Yes\)	psy findings available ompletion of cause of			
e E	ian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?					ace of Death (Check		2 42 110					
₹	Physic this co	은	1 Yes 2 No	Hospital:  1  Inpatie  28a. Date of inju	ent 2 ER/Ou	utpatient Time of	3 DOA Othe	4 L Nursing Ho	ome 5 X Res			v)			
0	ding I th. After funer	cate	1 Natural 5 Pending 2 Accident Investig	(Month, Day		injury	work'	Yes 2 No	280. Describe	now injury oc	curred				
Divisio	al or Atten s after dea I Directors d in by the	Certificate:	3 Suicide 6 Could r 4 Homicide determi	ot be 280 Place of Init		arm, stree	et, factory, office			(Street and No wn, State)	ımber or Rura	l Route Number,			
_	Hospita 24 hours Funeral leted filler	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of ex	xamination and/o	or investig	gation, in my opinio	n, death occurred a	t the time, date	and place, and	d due to the ca	suse(s) and manner stated.			
	To th withir To th comp	2	29b. Signature and title of certifier	les V			29c. License			29d. Date si	gned (Month, ber 7,	Day, Year)			
	12 v		30. Name and address of person v		eath (Item 23a)	(Type, Pr		10							
	lav		G Coleman, M.D.				ckville,	MD 20850	)						
	Sta Registr		31. Date filed (Month, Day, Year)  DFC 1 2 2012	Server 8	er's Signature	4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First\_Middle, Last) Physician/ Medical Examiner Location of Death 4c. County of Death 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore **Funeral** Months **Director** 1 M 2 F 28e-f show 10a. State 10d. Inside City Limits 10c. City, Town or Location event, the Medical Examiner must be notified at Director 1 ☑ Yes 2 ☐ No MOR 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2 items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education ecify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. I other then " Elementary/Secondary (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) should be filed and Mental H ٩ other treumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Importent: If item 27 is eny injury or other tree once. 20a. Method of Disposition 20b. Place of Disposition (Na cemetery, crematory of 1 Warial 2 Cremation 3 Removal from State 4 ☐ Danation 5 ☐ Other (Specify) 21. Signa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stomach cancer Pnysician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). signed by the attending physicien and deed be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physicien: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe 1 🗌 Yes 2 🗌 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No ᇛ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ns RajapameMD DOUS 7465 12/7/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NS (49 494 DEMP)

283 5 Sm / Th AV MO 21209 5 203

Registrar
DHMH 17 Rev 06-2011

State

UEC 1 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 26, per phy, g934 12-12-12 sm
State of Maryland / Department of Health and Mental Hygiene
Amend #5, per fh. g938 4-11-13 sm

Reg. No. 2012 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 8, 2012 Elsa G. Kelley 3:43 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Heartlands Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Secial Security Number 1 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Director 83 1 🗆 M 2 🕱 F Yrs July 22, 1929 New York show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 28a-f s MD Columbia 1 🗌 Yes 2 💢 No Howard 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? event, the Medical Examiner must be Funeral 23a 6902 Raven Lane 21044 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: If Yes Give "natural", 3 X Widowed 4 Divorced Specify. Completed Year or Dates 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Food Service Supervisor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Orsino Zulli Rose Anna Vinci other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Ochs Daughter 6902 Raven Lane; Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition Department of h Important: If ite any injury or ot 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 12/11/12 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fw eral Service tipensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy ò Month Day Year Pregnant at time of death Other (specify) the detached g Unknown g 
Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has to completely filled in by the funeral director, page 28. autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living Hospital: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Othe Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗆

State Registrar 29b. Signature and title of certifier

30. Name and address of perso

31. Date filed (Month, Day, Year) **DEC 1 2 2012** 

Andrew Lazris, M.D.

(IND

6334 Cedar Lane #103

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D47447

Columbia, MD 21044

29d. Date signed (Month, Day, Year)

December 10,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 10:45 December Mary Kathleen Kerns Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Regency Park Gambrills If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Min. (Month, Day, Year) 216-22-5015 Director 1 □ M 2**X**□ F July 18,1926 Maryland 86 Usual Residence of Dec or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location **Funeral Director** 1 Yes 2 No Bowie MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20715 3013 Tanbark Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Sector Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bernard Grabenstein Marie Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3013 Tanbark Lane Bowie, MD. 20715 John Kerns/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State **Huntt Crematory** 12/13/2012 Waldorf, 21. Signature Funeral Service 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between On et and Death th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Month Dav Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 1 Yo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 other (Spe AJSLI 1 ☐ Yes 2 ♠ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred LIVIL

Hospital or Attending Physician: The law requires that the death certificate be execu Division of Vital Records, Director: After this filled in by the

28c. Injury at work? 1 ☐ Yes 1 Matural 5 Pending 2 🗌 No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29c. License number 29d. Date signed (Month, Day, Year)

who gompleted cause of death (Item 23a), (Type, Print)

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for but

State

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harold Don Frederick Keller 2012 6:30 PM M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Corsica Hills Nursing & Rehab Centreville Queen Annes If Under 1 Year If Under 24 Hrs Date o. (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 - F Months Days Hours 207-24-4507 78 **Director** Jan Í934 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Queen Annes Centreville 1 Yes 2X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be Funeral 23a 800 Church Hill Road 21617 items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Hygiene. other than "natural", 3 Widowed 4 Divorced 159-61 Year or Dates. traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 laborer factory and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harold Elbert Keller Irene Elizabeth Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is Laurie Price/daughter 715 Oak Street Denver, PA 17517 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury 4 X Donation 5 ☐ Other (Specify) Signature Funeral S State Anatomy Board 655 W. Baltimore Street Made, Director MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) anu Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed the burial-transi Cause (Disease or imjury and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 2 No ed by the a detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this 24 hours after death.
Funeral Director: After thi eted filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

Medical

29a. Certifier

(Check only one) 29b. Signatur

and title of certifier

Day, Year) 2012

within 24 hou

To the Fune

completed file

1081)(Dosl

person who completed cause of death (Item 23a) (Type, Print)

ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

032136

Dr.w Chipi, W

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar			d / Depa		lealth an	d Mental Hyg		40030
ı	Physici	an	Decedent's Name (First, Middle, Last)     EDITH			KISTN	TED		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give	street and number)		VISIL	4b. City, Town, or	r Location of F		R 6, 2012 4c. County of Dea	8:30 P M
	Examin	er	FRANKLIN WOODS NU		CILIT	Y	ROSEDA		Joan		'IMORE
	Funeral Director		217-24-9701	7. Age	e (In yrs. la 85	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birth (Month, Day, 7–14–19	Year) 9. Bir C 27 MAF	thplace (State or Foreign ountry) RYLAND
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary B-f sh	tor	MD BALTI	MORE			ROSEDA	ALE			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code		11	og. Citizen of What C	
	sath w		1231 KENDRICK ROA	12. Was Decedent I	Ever in 11 9	3 13 1	Was Decedent of H	21237	2 (Specify Yes or No-	U.S.	
0000	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "neturel", or items 23e or 28e-f show event, I've Medical Examiner in ust be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☒ N  If Yes, Give  Year or Dates:			fYes, specify Cuba	an, Mexican, P	? (Specify Yes or No- Puerto Rican, etc.)	Black, Whi	
5	72 ho natur	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)		(Give	dent's Usual Occup	durina most of	f working	16b. Kind of Business	s/Industry
7	within ane. than *	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	`life. I	DO NOT use retired	MAKER		OWN	HOME
2	filed Hygi ther int, I		17. Father's Name (First, Middle, Last)		]		120.12		Name (First, Middle, M		
	should be ind Mental marked o umatic eve	To Be	CARL	HOFF	MEIS'	<b>T</b> ER		ANNA		UNKNOWN	
, Mary	od 2 lith a 27 lo	ľ	19a. Informant's Name/Relationship (Ty PATRICIA SUDINA/DA				ng Address (Street 6 ROUNDWO		or Rural Route Number, AD TIMONIU	*	Zip Code) 093
ore	Pages 1 ar		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □ F	Removal from State	CE	emetery, cren	sition (Name of natory or other plac			20c. Location · City of	
Saltimor	II. Pag rtment rtent: njury		' 4 □ Donation 5 □ Other (Specify)		ZION		LUIH CHURCH		2-10-12 CVACH /ROSE	ROSEDALE	
מ	permil. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licens			The second of	211 CHES		3 PED \$1 4900 CEN DOSCO.		21237
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	ne. LEUY a consequ	voni	15to et l'	ng, such as ca	rdiac or respiratory arre	sst,	Approximate Interval Between Onset and Death
,00/00	leath certificate be executed attending physician and I for use as the burial-transit	Medicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ience of):					
O. BOX	0 0 0	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	elivery Day Year
ras, r.	sign sign d be	by	Part II. Other significant conditions co	No. 1	ut not resu	ilting in the u	nderlying cause giv	ren in Part I.			to the cause of death?  Probably 4 nknown
Hecords	The law ate has b page 2 si	Completed			<del> </del>				24a. Was a autops perforr	v prior to	utopsy findings available completion of cause of s
Vital	Physicien: this certificated director,	Be	25. Was case referred to medical examiner?	Hospital:			Oth		Death (Check only on		
ō	Phys r this ral di	. To	1 Yes 2 No	1 ☐ Inpatie		ER/Outpatier 28b. Time of	it 3 DOA	Nursi	ing Home 5 Reside	once 6 □Other (Sp ow injury occurred	ecify)
00	Attending I or death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	Wor		. 4		
DIVISION	el or Attendi s after death. Il Director: A sd in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, etc.	ury · At ho c. (Specify	me, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number or F 1, State)	Rural Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical			f examinat				place, and due to the coocurred at the time, d	ate and place, and du	ue to the cause(s)
	To the To the Comp	×	29b. Signature and tille of certifier				29c. Licens			9d. Date signed (Mor	nth, Day, Year)
	I M			_	am		0	5346	, 2	15/2/1	2
	- Sho		30. Name and ad less of person who come and ad less of person who come and ad less of person who come and address of person who come address of person who come address of person who come and address of person who come add			2305	Print) Win	dswey	A Follo	m, not	FYOIS DI
	Sta Registi		NFC 1 2 201			ha	see s				

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Month Physician/ 11.30 PM 2012 December Kennard Francis Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Genesis Health Care Parkville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) Director 215-34-5062 1 M 2 D F 76 Nov 6, 1936 NY Usual Residence of Deci 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene. I then the marked other then "natural", or items 23a or 28a-f show item 27 is marked other then "natural", or items 25a or 28a-f show the traumatic event, the Medical Evaniner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count filed within 72 hours after death with the Maryland Director 1 Yes 2X No Parkville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21234 1801 Wentworth Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Design Engineer Black and Decker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H 2 Н. Emily Chenoweth С. Kennard, Jr. Raymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) .O. Box 1085 Bel Air, MD 21014 Richard Kennard Brother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Depertment of Important: If it any injury or o ₽ Hampstead, MD Carroll Cremation, Inc 12-12-2012 4 Donation 5 Other (Specify) 21. Sign are of Fun ce Licenses 22. Name and Address of Facility 11824 Reisterstown Reisterstown, MD Road 21136 J. Wayne Osterling ELINE FUNERAL HOME 1 Filter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Orebovaru Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospitei or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2 autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Division of Vital 8 25. Was case referred to medical examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မြ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31464 10 MD

State Registrar MD

821 N. ENTAW ST Sonte 308 BALTIMOPEMD214

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

HASHMI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da Physician/ 0950 M Christopher Kuhn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown 9. Birthplace (State or Foreign 5. Social Security Number unk 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) Director 65 1947 ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location Director 1 Ves 2 No MD Washington Hagerstown 10f. Zip Code 10e Street and Numbe 10g. Citizen of What Country? Funeral 615 Virginia Avenue 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. unk 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene, 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Meritus Medical Center 11116 Medical Campus Road Hagerstown, MD 21742 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 🔲 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 【 Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 2120 21. Signature of Fundamental 655 W. Baltimore Street art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Month Physician uno cancer disease or condition resulting in death) Medical Due to (or as a coverquence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 es, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy 3 in the past 12 months? Month Day Pregnant at time of death Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Ves 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner?

1 Yes Other: 2 00 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License numbe

State Registrar Hill Ave.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ana

31. Date filed (Month, Day, Year)
DEC 1 2

M.D

Registrar's Sig

12-08814 Faith Kinsey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2	0	March Street	2	1.	0	0	3	1

	Re	ror State gistrar			Certino	cate of l	Deam					Reg. No.			
Physician/ Medical Examiner	1.	Decedent's Name (First, Middl Faith Kinse									Date of De Month Vovembe	ath Day er 20, 201	Year 2	3. Time of D 0629 h	
	48	n. Facility Name (if not institution Harbor Hospital Cente	-	number)		41	City, Tov Baltimo		ocation of	Death		4c. Co	ounty of De	eath	
Funeral Director	5.	Social Security Number un			n yrs. last bi	rthday) Yrs.	If Under	Year Days	If Under Hours	Min.		17, 19	For	Birthplace (State reign Country)	unk
aoy		sual Residence of Decedent  2a. State 10b. County			c. City, Tow	n or Locatio	n				0 0 11.)		-	10d. Inside	City Limits
≱	L	MD			Ва	1timo	re 10f. Zip C					10g. Citizen	of Mhat C	1 Yes	2 No
the Maryland a or 28a-f sh tified at once	10	De. Street and Number 5111 Brookwoo	od Av <b>e</b> nu	e			Tor. Zip G	212	225			•	JSA	our a y ?	
Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.  taot: If item 27 is marked other thao "oatural", or items 23a or 28a-f sho or other traumarite event, the Medical Examloer must be notified at once.  To Be Completed by Funeral Director	1	Never Married 2 M	1 Y	d Forces?		If Ye	s, specify (	Cuban,	Mexican, I	n? ( Spec Puerto Ri	ify Yes or N can, etc.)		White, etc	- American Indian, Black, , etc.	
3 Widowed 4 Divorced if Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual during most of wor  Elementary/Secondary (0-12)  College (1-4 or 5+)										ind of wor	k done ur			hite ss/Industry	unk
036 ithin 72 h one. rr thao "c	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  unk  17. Father's Name (First, Middle, Last)  College (1-4 or 5+)  unk  18. Mother's Name (First, Middle, Last)														
21215-0036 suld be filed within 7 Mental Hygiene. marked other that is event, the Medica TO BE COMPIL		7. Father's Name (First, Middle, Last)  unk  18.Mother's Name (F  9a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rur										, Maiden Su	rname)		unk
MD 21 nd 2 should I ulth and Mer m 27 is man a umatic cv	1	9a. Informant's Name/Relations O.C.M.E.		umber, City ltimor											
Ore, Nges 1 and to of Health	1	Da. Method of Disposition  Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)												y or Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hyggene. Important: If item 27 is marked other than iojury or other traumatic event, the Medical To Be Comple	2	Donation 5 Nother Specify in state  1. Specture of Eureral Strice House, Director  Ronal String Director  Ronal String Director  Baltimore, MD 21201											e Stree	t	
Physician	2	3a. Part I. Enter the disease, o failure. List only one cause	e on each line. (	Cocain	e Into	not enter the	e mode of	dying, s	MD as ca	ZIZUI irdiac or r	L espiratory a	arrest, shock	, or heart	Approxima Between	ate Interval Onset and
xaminer		mmediate Cause (Final disease or condition resulting in death)		elerotic Grasseques as a consequence		ular Disc	ese								eath
le l	S if	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause		as a consequ	uence of):										
ited d ansit Examiner	(	Disease or injury that initiated events resulting in death) Last	U	as a consequ	uence of):										
760, ficate be executed g physician and is the burial - transit		UNPENDED	AMEND									100	2 ( ( ) .		
). Box 68760, the death certificate be execu- by the attending physician and sched for use as the burial - tra Physician/Medical	18 23	F FEMALE: Bb. Was decedent pregnant in past 12 months?	the 1 L	yes, outcome ive birth regnant at tir		2 Fet	al death	3 [	Ectopic	pregnand	СУ		Date of deli onth	Day	Year
Box 68 he death certi the attendin hed for use a	1	Yes 2 No 9 Ur	nknown 9 l	Inknown		3 Ou	ner (Specia		iven in Par	rt I	23e Die	tobacco us	e contribute	e to the cause of	death?
ires that to signed by I be detac	5		- Contribut			ung in the d	nderrying c				1 🗆	Yes 2 1	No 3 I	Probably 4	Unknown
Records, P.O. I The law requires that the ficate has been signed by the page 2 should be detache Completed by PP	and in									<del></del> -	pe	as an topsy rformed? s 2 No	prior deat		
H. The		25. Was case referred to medic	al T				26	S.Place	of Death (	Check or				100 2	
Vital ysician ysician directo	ĭ	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 🗸 ER	/Outpatient	3 DO	)A	Other <sub>4</sub>	Nursing	Home 5	Residence	e 6 0	Other:	
in of \alpha oding Phy h. : After the funeral of funeral oding.	11	27. Manner of Death	a dima	Date of Injury Month, Day,Yea	ır)	b. Time of li		-	y at Work′ ′es 2 🛣		28d. Descri	oe how injury	occurred		
ivisior I or Attend after death. I Director: d in by the I	2 Accident Investigation Investigation Fd:11-20-12   Id: 5:30 am 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State) 5:111 Brooksycood														
		Homicide  29a. Certifier 1 Certifying	Physician: To the	e best of my	Resid	death occur	red at the t	ime, da	te and pla	ice, and d	lue to the c	ause(s) and ate and place	manner as	stated. to the cause(s)	
To the Ho within 24 To the Fu completely	g -	29b Signature and title of certification	and mar	ner stated.	la				e number					(Month, Day, Ye	ar)
		6 Cur	11	1	oth (Item 33	31		O.C.I	И.Е.			Nove	mber 21	, 2012	
		30. Name and address of person Zabiullah Ali, M.D.	Assistant M	edical Exa	aminer	900 W. E		Stre	et, Balti	more, l	MD 2122	3			
Stat Registra	te ar	31. Date filed (Month, Day, Yea	2012	2. Registrar's	s Signature	park	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nelson Liles 2012 11:55p M December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 3228 Beret Lane Silver Spring 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 455-34-1199 Days **Director** 1 XM 2 🗆 F 84 Nov 13, 1928 Kansas Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 3228 Beret Lane or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 □ No If Yes, Give 1951 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian or than "natural", or iter the Medical Examiner 1 Never Married 2 Married <u>Ş</u> Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1951 White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Je filed with... \*al Hygiene. \*ar than "r 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) : should be filed with and Mental Hygien is marked other th Technical Writer Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Regina Mae Dickinson F. Wayne Liles age 1 and 2 should be not of Health and Mer t: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ann Liles/daughter 3228 Beret Lane Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State permit. Page Department c Important: If any injury or injury or Final Journey Crematory 12/10/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) rvice Acens 21. Sign & e of Funeral Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Prostate Cancer Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease or injury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as nding p IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Day Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown ed by the a a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires should b 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 🗌 No Yes 2 No 1 🗌 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XResidence 6 Other (Specify) Hospital: ျှ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury death. Accident Investigation 1 Yes 2 No 24 hours after deat Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

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State Registrar G Coleman, M.D. 1355 Piccard Drive Rockville, MD 20855

31. Date filed (Month, Day, Year)

A 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

December 10, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. Day 2012 Year 9 8:44 AM Bong Yeul Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Gilchrist Hospice Care Columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Months Director 218-02-1204 1 M M 2 □ F 04-08-1941 Korea 71 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Burtonsville 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? **Funeral** 20866 United States 3831 Wildlife Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed 3 Widowed 4 Divorced Asian Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Dry Cleaning Owner/operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Young Sook Kim Jong Sik Lee other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7674-1 Maple Lawn Blvd., Fulton, Maryland 20759 Mr. Ki Lee - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State Glen Burnie, MD Atlantic Crematory 12-10-2012 4 Donation 5 Other (Specify) 21. Signature f Funeral 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 7250 Wash. Blvd., Elkridge, MD 21075 MMP Inc. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition LIEON Medical resulting in death) s a consequence of): Examiner Sequentially list conditions, it any least immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to jor as a conjuguence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 X NO 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No м Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in manufacture and the course of the cause Medical 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature ag d title of certifie J icense number 29d. Date signed (Month, Day, Year) 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) eder lane Coumnie 31. Date filed (Month, Day, Year) DEC 1 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 10, 2012 Ling Lin 0445 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 13109 Piney Knoll Lane Potomac Social Security Number If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 26, 1964 Days Hours Min **Director** 1 🗆 M 2 🔀 F 587-63-1920 Taiwan, ROC 47 shov 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2X No MD Montgomery Potomac 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? pe items 23a ner must be Funeral USA 20854 13109 Piney Knoll Lane Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. ō Examir þ 1 Never Married 2X Married Yes 2X No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) **5+** Elementary/Secondary (0-12) the Mortgage Company Software Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic even မ Neau Chiao Lin Chia Chu Lin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13109 Piney Knoll Lane Potomac, MD 20854 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Der-zy Jack Maa/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/12/12 Woodbine, MD 4 Donation 5 Other (Specify) Signatur of Funeral Service Licensee Going Home Cremation Service Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician) Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ed by the atter 3 Ectopic pregnancy The law requires that the death in the past 12 months? Month Year Day Pregnant at time of death Other (specify) Yes 2 No g 🗌 Unknown 9 V Unknown Division of Vital Records, P.O. been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 Yes 2 No I or Attending Physician: after death.
Director: After this certifications 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 😾 Residence 6 🗆 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 XNatural 5  $\square$  Pending injury Accident Investigation filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital of 24 hours af Funeral D Medical

To the within 2

29a. Certifier

(Check

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive Rockville, MD 20855 Coleman, M.D.

31. Date filed (Month, Day, Year) **DEC 1** 2 2012

Registrar

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Yea December 11, 2012

29c. License number

D37142

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #27, PER ORGINAL CERT, 6934 12/12/12 TRT
State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Year **Physician** September 18 2012 Lee ala /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY 11708 WILLOW CREEK LANE CUMBERLAND Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Social Security Number **Funeral** Days Hours Min 1**X**) M 2□ F Yrs SEPT. 22, 1951 MARYLAND Director 60 219-56-7602 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Ever: it is not be notified at 10a. State 1 ☐ Yes 2 X No Director CUMBERLAND ALLEGANY MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21502 11708 WILLOW CREEK LANE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married WHITE 1 ☐ Yes 2X No If Yes, Give Year or Dates: 71–73 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME IMPROVEMENT PAINTER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHIRLEY JOANN RADCLIFF ROY A. LEWIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11708 WILLOW CREEK LANE CUMBERLAND, MD 21502 SHIRLEY HELMICK/ MOTHER Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STATE ANATOMY BOARD 21. Signature of Funeral Service Licensee 655 W. BALTIMORE STREET BALTIMORE, MD 21201 RONALD S. WADE, DIRECTOR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or is a insequence of): Examiner poles Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a runsequen Examiner Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, NI Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Dav Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Tesidence 6 ☐ Other (Specify) Hospital: 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After Hospital or Attending 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIENN 32. Registrar's Signature Year) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death November 30, Physician/ 2012 8:34 PM M Gladys V. Landon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Worcester Atlantic General Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 215-62-1137 1 🗆 M 2 💢 F June 5, 1952 Maryland 60 Usual Residence of Deceden shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified 1 🗌 Yes 2 🔽 No MD Worcester Pocomoke City items 23a or ner must be n ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2404 Lilac Lane #B 21817 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian ural", or iter Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 X Divorced 2 should be filed within 72 hours and the and Mental Hygiene.

27 is marked other than "natural content the Medical Expression." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) transportation bus driver Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary E. Morgan Jesse W. Mariner Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Rachel Sprinkle/sister 2404 Lilac Lane #B Pocomoke City, MD 21817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 

Burial 2 

Cremation 3 

Removal from State jn state 4 ☐ Donation 5 X Other (Specify) Highature of Funeral Privide Limite Wide Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 031 DP disease or condition resulting in death) Medical Due to (or as | consequence of) **Examiner** emorna Sequentially list conditions Examine if any, leading to immediate cause. Enter Unidentity Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical for use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ructille 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 🗌 No 1 🗌 Yes Yes filled in by the funeral director, 25. Was case referred to medical Vital 26. Place of Death (Check only one) Be examiner? Hospital မှ 1 Alnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural To the Hospital or Attending 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) GLADYS 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) Physician way 4353 12/1/12 30. Name and address of person who combleted cause of death (Item 23a) (Type Print)
IIKAS SAYAL, 9733 Healthway drive Berlin, W 21811

Registrar

2034

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32. Registrar's Signature

Maryland 21215-0036

Baltimore.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month 1 Physician/ 11:00 AM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Anne Arundel Tate Hospice House Linthicum If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days 215-07-4073 1 □ M 2 🗓 F Director 98 Dec. 31,1913 Maryland 2 should be filed within 72 hours after death with the Maryland thit and Martel Hygiene.
27 is marked other than "natural", or Items 23e or 28e-f show treumatic event, the Madical Ex., in printed the notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Maryland N/A Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4410 Prudence Street 21226 F Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 ဩ No 1 X Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 A No Specify: Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Hutzlers Dept. Store Distribution Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Paga 1 and 2 should be filed Depertment of Health and Mantel Hy Important: If Item 27 is marked oit any injury or other traumatic even once. မ Milash Lunskis Peter Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph Kalivoda (nephew) 918 Indian Creek Lane Crownsville, Md 21032 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Holy Cross Cemetery 12-12-2012 1 A Burial 2 Cremation 3 Removal from State Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ashley MO1682 Cully-Polyniak Funeral Home. P.A. 7 E. Patapsco Ave. Baltimore, Maryland 21225 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a conseductice of erai Director: After this cartificata hes bean signed by tha ettanding physician and filled in by tha funeral diractor, paga 2 should ba datechad for use as tha burlei-transit Hospital or Attending Physician: The lew raquiras that tha death certificate ba axacutad that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 🗌 Yes မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28a. Date of injury 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 24 hours eftar death Funeral Director: A Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hour To the Funer complately fi 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month.

Day, Year) 12

	Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.  #20b Per FH G934 12/27/2012 JH State of Maryland / Department of Health and Mental Hygiene														
			1 - For State Registrar	State of Maryla		tificate of			Reg. No 2	012	40042				
1	Physicia Medi		1. Decedent's Name (First, Middle, La Dorothy	ast) Inn Millior	2			Month	2. Date of Death  Month Day Bay Bay Bay Bay Bay Bay Bay Bay Bay B						
	Examir		4a. Facility Name (if not institution, give	e street and number)			or Location of Deat	h	4c. Co	Balti					
Ī	Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)  Yrs.	If Under 1 Year Months Day	ar If Under 24 Hrs		th		place (State or Foreign				
	and show	ğ	Usual Residence of Decedent	10c. C	ity, Town or Loc		1944	-	10d. Inside City Limits						
	ha Mary or 28a-f	Director	MD Balt 10e. Street and Number	imore	Owir	195 Mi			10a Citizer	n of What Cou	1  Yes 2 No				
	ms 23a must be	Funeral		Mill Way	- I40 V	2	21117		).	USA	<u>\</u>				
9036	ge 1 and 2 should ba filad within 72 hours eftar death with tha Maryland nt of Haaith and Mantel Hygiana. If fem 27 is marked other than "natural", or itams 23a or 28a-f show or othar traumatic event, the Medical Examiner must be notified at	<u>중</u>	11. Marital Status  1 💢 Never Married 2 🗌 Married  3 🗎 Widowed 4 🗎 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates.	11	Vas Decedent of Yes, specify Cu	f Hispanic Origin? (S iban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White, ecify: Black					
21215-0036	in 72 hor a. ian "nat Neofe	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed) College (1-4 or 5+)	(Give k	ent's Usual Occ and of work don NOT use retire	e during most of wor	rking		of Business/Ir	,				
	ad withi Hygian other th	Be C	12th grade 17. Father's Name First, Middle, Last,	NIA	(	Caregiu	1			Priva	te				
r dan	18. Mother's Name (First, Lessie) Mo														
5 A.M. Maryland	Elementary/Secondary (0-12) College (1-4 or 5+)  12th grade  17. Father's Name/First, Middle, Last)  18. Mother's Name (First, Middle, Maide Less)  19a. Informant's Name/Relationship (Type, Print)  Adrian M. Gwenfield Daughter  20a. Method of Disposition  19b. Mailing Address (Street and Number or Rural Route Number, City HTD3 Winter Mill Way Owing Less)  20a. Method of Disposition  20b. Place of Disposition (Name of Last Apale of Less)														
4:15 altimore,	Page 1 and nent of Hant; If ite		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	Place of Dispos cemetery, crem TUMATIS	natory or other p	101	272012	1.1	tion - City or Ti					
Balt	The Bunal 2 be Cremation 3 Removal from State Cremation Center 12/13/2012 Hanove 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Vaughn C. Greene Full 8728 Liberty Road Randall Stown														
			23a. Part 1. Enter the disease, or cor shock, or hear failure. List only Immediate Cau: (Final	nplications that caused the dea one cause on each line.			-36				Approximate Interval Between Onset and Death				
	Physician/ Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consec		DEHEN	TIA			-	Onset and Death				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a consequence of):											
12	axecuterian end	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consec	quence of):					- 4					
8, 20. <b>68760</b>	icata be physicia is tha bu	edica	•	d											
BOX	The law requires that the death certificate be ate has been signed by the attending physici paga 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregn 1  Live Birth 2 Fet 4  Pregnant at time of 9  Unknown	taldeath 3 🗌	Ectopic pregna Other (specify)			<b>2</b> 3d	I. Date of deliv Month	very Day Year				
P.O.	as that t signed b	ξ	Part II. Other significant conditions	contributing to death but not re	sulting in the ur	nderlying cause	given in Part I.		5/		he cause of death?				
LTON DE OF VITAL RECORDS,	w raquir s bean s 2 should	Completed					-	1 🗔		4b. Were auto	bably 4 Unknown				
Rec	autopsy performacy?  1 □ Yes 2 D No									prior to co death? 1  Yes	ompletion of cause of				
∛ /ital	ysiclan: The is cartificate director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	3 50/0	10	Place of Death (Che								
MILTON on of Vil	ding Phy h. After this funeral o		27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inj		lome 5 ☐ Resid 28d. Describe h			()				
•==	Attending Physiclan: or death. sctor: After this cartific by tha funeral diractor,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rura												
DOROTHY Divis	To the Hospital or Attending Physician: within 24 hours after death.  To the Funaral Director: After this cartific completely filled in by tha funeral director,														
DOF	the Hos hin 24 hi the Fun npletely	Medical	only one) 3 X Certifying Nu	niner: On the best of my knowniner: On the basis of examinations: To the best of	on and/or investi	gation, in my opi	nion death occurred	at the time date a	nd place and	d due to the ca	use(s) and manner stated				
	o viii So o		29b. Signature and title of certifier	LES GINF		29c. Licer	19792		10/1	gned (Month,	Day, Year)				
_	21		30. Name and addless of person who JACKIE JONES	, CRNP 2300 D	ULANEY	VALLEYR	OAD, TIMO	NIUM, MD	2109.	3					
	Sta Registra		31. Date filed (Month, Day, Year) DEC 1 2 2012	32. Registrar's Signa	park	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Month , 1. Decedent's Name (First, Middle, Last) Physician/ Medical 00615 Vecembe 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** andallstown Hospital North West Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 36.189 Director 1 - M 2 XF 1930 13 show 3a or 28a-f shov t be notified at 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director (Sandall stown 1 Yes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a c 21133 Funeral USA 8604 Luceme . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status ian "natural", or iter Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ò 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black If Yes Give 3 NWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mexicone. Elementary/Secondary (0-12) College (1-4 or 5+) Night Club Business 12tharade NIA DWINEY Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8la4 Lycerne Road Randallstown MD 2133 God Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 1213/2012 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address Facility Vallahn C. Green & Funeral Services Signature of Funeral Service Licenses Liberty Road Randall Frown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical disease or condition resulting in death) Examiner quentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Day Pregnant at time of death 9 Unknown P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available 24a. Was an nis certificate has b I director, page 2 sl performed? Yes 2. No 1 Yes 2 X No this certificate 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Hospital: ျ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 242810 Gramatikova, Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Aneta Gramatiko va 5401 Old Court Road, Randallstown, ND, 21133

State

Aneta 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month 0416 4c. County of Death 4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days Hours Country) 1 🛣 M 2 🗆 F Nov 10, 1947 California 65 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🔀 Yes 2 □ No Baltimore 10f. Zip Code 10g. Citizen of What Country? 21218 USA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 ☐ Yes 2 🔀 No Specify: Specify: black unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry College (1-4 or 5+) laborer unk 18. Mother's Name (First, Middle, Maiden Surname)

1. Decedent's Name (First, Middle, Last) Physician/ Michael L. Montgomery Medical 4a. Facility Name (if not institution, give street and number) Examiner Union Memorial Hospital 5. Social Security Number UNK 6. Sex **Funeral** Director or then "netural", or items 23e or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State Director MD 10e. Street and Number Funeral 2700 N. Charles Street 11. Marital Status 1 Never Married 2 Married ≥ Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 🏋 Divorced Completed (Specify only highest grade completed) filed within 72 ral Hyglene. Elementary/Secondary (0-12) of Health end Mental Hygle of Health end Mental Hygle ff Item 27 Is marked other in other treumatic event, it Be 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 5809 Waycross Road Baltimore, MD Charlese Nobel/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1 of Pepartment of Importent: If Ite eny Injury or of Office. cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Specify) jn state 21. Signature of Fr. Sh Director 22 Name and Address of Facility Board 655 W. Baltimore Street MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Betwe Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physician and I for use as the burial-transit Hospital or Attending Physicien: The law requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) been signed by the eshould be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has ballinector, page 2 s 1 ☐ Yes 2 ☐ No Yes 2 No : After this certifica e funeral director, p 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Dinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending Division 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Box 68760 within 24 hours after death.

To the Funerel Director: Aft completely filled in by the fu

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARKWAY BALTIMORE UNIVERSITY 31. Date filed (Month, Day, Year)

State Registrar 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2012 Kromber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign **Funeral** 80 August 20 Director death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director More 10g. Citizen of What Country? 10f. Zip-Code 212 Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuhan, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 2 No δ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than matic event, the Me 18. Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last, Be ٩ 19a. Informant's Na e/Relationship (Type. Print) 19b. Mailing Address (Street and Number s Department of Health a Important: If item 27 Is any Injury or other trau 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation Date, December 3 Removal from State 4 Donation 5 Other (Specify) W. DABROWSKI-ChoTNACKI FUNER 1005 DUNDAIK AVE. BALTIMUER 21. Signature of Funeral Service Lice Bert 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ¿/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🗌 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 🗌 Yes 2 No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🔏 Inpatient Other: 4  $\square$  Nursing Home 1 ☐ Yes 2 🔀 No 3 DOA 5 Residence 2 ER/Outpatient 6 Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 Tes 2 🗌 No death Director: A id in by the f Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after to the Funeral Direct 4 - Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number VV00 10,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DEC 1 2 2012

sack

0/00 November 50,2012 Baltimore, Maryland 21215-0036 Grrala, Pedro Division of Vital Records, P.O. Box 68760

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Physicia		Decedent's Name (First, Mi Pedro Orral									2. Date of D Month	1	Day	Year	3. Time (	of Death
Medic Examin		4a. Facility Name (if not institu Shady Grove	tion, give street and num	Hospita	-1	4	lb. City, T	own, or	Location	of Death						- /( W
Funeral Director		5. Social Security Numberum 219–75–6868		7. Age (In yrs.		V	If Under		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D			*	place (State	or Foreign
land f show d at	tor	Usual Residence of Deceder 10a. State 10b. Cou		56 10c. C							Oct 2,	19		<u>uador</u> 10d. Inside (	City Limits	
h the Man la or 28a- be notifie	al Director	10e. Street and Number	gomery		MOntgomery Village							10g.		es 2X No unk		
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s after des al", or ite	ρ	11. Marital Status  1  Never Married 2   3  Widowed 4 Divor	Armed Fo	2 🔼 No e	unk	If Ye	es, specif	y Cubar	n, Mexicar Specify:	n, Puerto	o Rican, etc.) Black, Wh				can Indian, etc. spanic	
hours natur dicel	olete		edent's Education ighest grade completed)		16a. D	16a. Decedent's Usual Occupation						110k 16h Kind of Busine				unk
within 72 /glene. ner than '	e Completed	Elementary/Secondary (0-1	-4 or 5+)	lif	(Give kind of work done during most of worki life. DO NOT use retired)  Handyman							ruct	ion			
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I and 2 should be filed within 72 hours after death with the Maryland theath and Mental Hygiene. If Health and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at		Segundo C  19a. Informant's Name/Relation Strady Grove	rala wife		19b. N	Maili <b>9:4</b>	A <b>3:9</b> es()	iredi	hai Mon be	Pilave	Yagual CoMonto rive Ro	gome	<b>21. Ty</b> wn <b>,\</b> \S	id ka g	3 <b>e</b> 9MD	<b>20886</b>
ge 1 and 2 t of Healt If item 2 or other		20a. Method of Disposition  1  Burial 2  Cremat		Ctoto	Place of D	Dispositi cremat	on (Name	e of ner place			Date	_	Location -			
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to the hospital or Attentioning Privations. The raw requires that the deam centricate be within 54 boars after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1										23d. Date of delivery Month Day				Year
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e has beel age 2 shou	Completed	, 0									24a. Was auto perf		] p		psy findings impletion of	
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his cel	To E	examiner? 1  Yes 2  No		Inpatient 2	] ER/Outpa	atient	3 □ DOA	Othe	-		me 5 🗆 Res	idence	6 ☐ Othe	r (Specify	)_	
eath. or: After t	Certificate:		anding 28a. Date (Monte estigation and not be	of injury th, Day, Year)	28b. Tim inju		28d M	work?		- 1	28d. Describe	how inj	ury occurre	d		
ra after d ral Direct		4 ☐ Homicide det	, factory, o				28f. Location ( City or To	wn, Sta	te)			ber,				
the Fune	Medical	(Check 2 L Mediconly one) 3 Certify	ring Physician: To the basting Nurse Practitioner:	is of examination  To the best of	on and/or in	nvestiga edge de	tion, in my	y opinior	n, death oc ne time dat	curred at	the time, date	and pla	ce, and due	to the ca	use(s) and m	
So o o		29b. Signature and title of cert	ifier	e of death (Iter	M	D	29c. l	License	number 315			29d. C	Date signed )Vem   E	(Month, 30	Day, Year)	<b>-</b>
		30. Name and address of pers	on who completed caus	e of death (Iter	n 23a) (Typ	oe, Print	Ding		Rou	lowil	e, M.	ang 1	rel	306	50	
Stat Registra		31. Date filed (Month, Day, Yea DEC 1 2	2012 Serve	egistrar's Signa	ature da	Ne	1									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ December Vural Oskay Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Min (Month, Day, Year) Country 107-30-9415 Director 1 XM 2 □ F Apr 19, 1933 Turkey permit. Page 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3813 Dorchester Road 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 

Widowed 4 □ Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) engineer aeronautics Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ali Izzet Oskay Ayse Hidayet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason Oskay/son 3813 Dorchester Road Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4X Donation 5 ☐ Other (Specify) Signature of Euneral Service Licenses 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Muncardeal Infarction disease or condition resulting in death) Medical Que to (or as a consequent e of): Examiner hour HVTEYIOSCLEYOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown ate has been signed by 1 page 2 should be detaci Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 2 No 1 🗌 Yes 3 Probably 4 Unknown 'ăscular Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitions. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D19558 son who completed cause of death (Item 23a) (Type, Print) 716 Mouden Choice Lane Baltimore MD 21228 Johnson

State Registrar 31. Date filed (Month, Day, Year)

25

3. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Barbara Elise O		N 1- For State	Sta	te of Maryla					d Mental I	Hygiene	9.2.01		1 00'	
Physici		Registrar  1. Decedent's Name (F	irst Middle	ast\		Certificate	e or De	atn		2. Date of Dea	Reg. No.	I 3 Tin	ne of Death	
Medical Exami		BARBARA	iiot, middio,	ELISE		os:	ΓRAW				Day Yea er 5, 2012		345 hrs	
1		4a. Facility Name (if no	,	•	umber)				Location of Dea	ith	4c. County c			
Funeral		Thomas B. Fin  5. Social Security Numl		Sex	Cumberland  7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24					Irs 8 Date of B	Allegany rs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (\$			
Director		218-84-155		M 2XF	// /igo (iii )			onths Days		lin.	5/1967	Foreign Country)		
		Usual Residence of De								1 03/13	0/190/		MD	
W any		10a. State 10b	. County		10c.	City, Town or I	Location						Inside City Limits Yes 2 X No	
yland n-f sho	햦	MD 10e. Street and Numbe	BALT	MORE		BALTIMO		Zip Code			10g. Citizen of Wh		Yes 2 kt No	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner, must be notified at once.	Director			TOURS II	4 77							at Country?		
with to ms 23s	펻	2837 QUAI		12. Was De	cedent Ever	in U.S. 13	3. Was Dec	21209 edent of His	panic Origin? (	Specify Yes or N		- American Inc	dian, Black,	
or ite	Fune	1 X Never Married	_	1 Yes	2 X N	lo			, Mexican, Puei	to Rican, etc.)	White	, etc.		
rs afte ural",	Ď	3 Widowed  15. Decedent's Educa		or Dates:		d) 16a Dec		2 X No	specify: ion (Give kind o	f work done	Specify: 1	WHITE	· · · · · · · · · · · · · · · · · · ·	
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filed v I Hygi		17. Father's Name (Firs	t, Middle, L	ast)		0.000					Maiden Surname)			
2121 vild be fil Mental F marked	To Be	JOSEPH  19a. Informant's Name/	Relationship	(Type, Print)		OSTR.	lailing Addr	ess (Stree	JUDITH	r Rural Route Nu	mber, City or Towi	MILLS	ode)	
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s l and f Heal If item		20a. Method of Disposi		3 Removal fr		Ob. Place of D crematory MIKRO	isposition (	radine of cer	netery,	Date	20c. Location -	City or Town,	State	
Baltimore, bermit. Pages I as Department of Hec important: If ite		4 Donation 5	Other Spec	ify:	om otato	BETH	ISRAE	L _	12	2/07/201	2 BALTI	MORE,	MD	
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Adillilei		or condition resulting in		Due to (or as a	a consequen	ce of):			L DANK					
	ē	Sequentially list conditi if any, leading to immed	diate	Due to (or as a	a consequen	ce of):						-		
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Box 68760, e death certificate but the attending physic ed for use as the but	ian/Me	IF FEMALE: 23b. Was decedent preg	nant in the	23c. If yes,	outcome of p	oregnancy	Fetal de		Ectopic preg		23d. Date of Month	delivery Day	Year	
x 68 th cert ttendin r use a	icia	past 12 months?		4 Pregr	nant at time o	of death 5	Other (			riaricy	Worth	Day	i eai	
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Fauncral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the broad the state of the stat	ğ	, are in odio, organioa	in condition	to contributing t	o death but i	lot resulting in	the underly	yii ig cause g	iveilii Paiti.		es 2 No 3	_	_	
Division of Vital Records, at an or Attending Property and or Attending Physician: The law require at Director. After this certificate has been sited in by the funeral director, page 2 should be	Completed		_					_		24a. Was			indings available	
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Vita	일		No		Inpatient 2	ER/Outpa	atient 3	DOA	Other Nur	sing Home 5	Residence 6	Other:		
n of diog Pl h. After funera		27. Manner of Death  1 X Natural 5	Pendin		of Injury n, Day,Year)	28b. Tim	e of Injury		ry at Work? res 2 No	28d. Describe	how injury occurre	ed		
ivision or Atteo after death Director:	icati	2 Accident	Investig	gation 28e Plac	e of Injury -	At home, farm,	street, fac			28f Location	(Street and Number	er or Rural Roi	ite Number City	
Division Hospital or Atteod 24 hours after death Funeral Director:	Certification:	3 Suicide 6 4 Homicide	Could r	not be				,		or Town,		, or rear at rear	ato rvanibor, otty	
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To the Hos within 24 h To the Fun completely	Medical			ner:On the basis and manner s	of examination	on and/or inve	stigation, ir			d at the time, date	and place, and d			
	2	29b. Signature and title		ب نب				29c. License O.C.I			29d. Date signed		iy, Year)	
		30. Name and address			se of death (	Item 23a)					1	-,		
2 V		Ling Li, MD	Assistant	Medical Exa			imore St	reet, Balt	imore, MD 2	21223				
St Regist	ate	31. Date filed (Month, D	2 2012	32. R	egistrar's 9g	nature	4							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 8, 2012 7:35 рм Young Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Yo Oct 4, 1 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Director 216-15-1303 71 1 □ M 2 🗓 F 1941 Koreá 28a-f show 10b. County permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20904 11815 Old Columbia Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Retail Salesperson æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Sung Duk Kim Bo C Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11815 Old Columbia Pike Silver Spring, MD 20904 Ok Soo Park/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/11/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ a. Metastatic Breast Cancer Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) 1 Yes 2 9 Unknown certificate has been signed by the iliector, page 2 should be detached 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗌 Yes 2 🔲 No Yes 2X N 25. Was case referred to medical 26. Place of Death (Check only one) Be Other:  $_4$   $\square$  Nursing Home  $_5$   $\square$  Residence  $_6$   $\boxtimes$  Other (Specify) hospice 1 Yes 2 XNo ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

0 0

Registrar

DHMH 17 Rev 06-2011

M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Bindu Joseph, 31. Date filed (Month, Day, Year)

2 2012

D60634

December 9, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year Paske 2245 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours Sep 9, 1928 Michigan **Director** 377-20-9476 1 □ M 2 🔀 F 84 Usual Residence of Deced 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. Count 10d. Inside City Limits 10c. City, Town or Location Director MD Montgomery Germantown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 20874 13105 Shadyside Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Secondary (0-12) Administrative Assistant Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ignatz Pashkowsky Stella Whytuk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 Deer Run Road Roanoke, VA 24019 John C. Chapman/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 12/12/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ a Metastatic Breast Cancer Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last **to the Funeral Director.** After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 hours after death. Funeral Director: After this certificate by 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

121

Registrar

DHMH 17 Rev 06-2011

State

Bindu Joseph, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2012

31. Date filed (Month, Day, Year)

D60634

December 8, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrate Certificate of Death ent's Name (First\_Middle, Last) 1. De 2. Date of Death 3. Time of Death Physician/ Medical cility Name (if not institution, give street and number) 4b. City, Town, or Location of Death d. County of Death Howard Examiner West Friendship Angels Touch Assisted Living If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 296-18-9887 90 1 □ M 2 □X= Aug 23 1922 OH 28a-f show 10b. County th and Marital Hygiane. 27 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Modical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Ellicott City MD Howard 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 Funeral 11744 Triadelphia Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 white 1 ☐ Yes 2 🗓 No Specify: If Yes, Give 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise Zitto John Galairde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Unverzagt (daughter) Paga 1 and 2 st ment of Health a ant: If item 27 is ury or other tra 11744 Triadelphia Rd., Ellicott City, MD 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Paga 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 A Other (Specify) TOMDIMENT Marriottsville, MD Crest Lawn Memorial 12-11-12 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License P.O. Box 195 Sykesville, MD 21784 00164 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any leading to immediat cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of sician and burlal-transit Examir the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mplately filled in by the funeral director, page 2 should be detached for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death this certificate has baen signad by the a raid diractor, paga 2 should ba datached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕽 😽 History Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division of Vital æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certific e of death (Item 28a) (Type Print) 30. Name and address on who completed cau 32. distrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		artment of Heal tificate of Deal			ene 2012	2 40052			
	Physicia Medic	n/	1. Decedent's Name (First, Middle Vong Wor						2. Date of Death  Month	Day 5 th Year	3. Time of Death 7:35 AM			
	Examin		4a. Facility Name (if not institution Howard Co	give street and number)	ral to	tosp.	4b. City, Town, or Locat	tion of Death	ià	4c. County of Dea	th			
	Funeral Director		5. Social Security Number 507-06-2049	6. Sex 7. Ag	e (In yrs. las	st birthday) Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day )	8. Date of Birth 9. Birthplace (State or For Month, Day, Year) Country) Korea				
	land f show d at	tor	Usual Residence of Decedent  10a. State  10b. County		10c. City,	Town or Loc	cation				10d. Inside City Limits			
	Mary 28a-i	irec	MD Howa	rd			E:	llicott	t City	1 🔀 Yes 2 □ No				
	th the	al D	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	, and the second			
	ms 2 musi	Funeral Director	4929 Webbed Fo	ot Way  12. Was Decedent I	Tues in 110	12.0	2104		nife Van er Na	United				
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 🙀 Mar 3 □ Widowed 4 □ Divorced	Armed Forces?		11	Vas Decedent of Hispanion of Yes, specify Cuban, Med Tes, specify Cuban, Med Tes 2	xican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: AS				
2-0	2 hour	Completed		nt's Education	T	16a. Deced	ent's Usual Occupation	most of worki	na 1	6b. Kind of Business	Industry			
121	ithin 7 ene. r than	Com	Elementary/Seconday (0-12)	College (1-4 or 5	i+)	life. DO	ONOT use retired) Owner/opera			Restau	ront			
	iled w I Hygi other ent, t	Be	17. Father's Name (First, Middle, I						e (First, Middle, Ma		italit			
Maryland	d be f Menta arked atic ev	욘	Cha Park					Hwar	ng Ahn					
Nar	shoul		19a. Informant's Name/Relations				g Address (Street and Nu							
e,	and 2 s Health tem 27 other tra		Kui Mai Park -	wife	20h Pla		webbed Foot sition (Name of			Oc. Location - City or	yland 21043			
mor	age 1 ent of nt: If it		1 👿 Burial 2 □ Cremation 4 □ Donaldon 5 □ Other (S		cei	metery, crem	natory or other place) dge Mem Parl	İ		Elkridge,				
Baltimore,	permit. F Departm Importal any injul		21. Signal Tre of Fune all Services	2.		22	. Name and Address of F	acility Gar	ry L. Kau	ıfman Fune	ral Home at			
			23a. Part . Enter the disease, or	complications that caused	the death.		MP, Inc, 725 or the mode of dying, such				Approximate			
J	Physician/		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each line	Pas	ume	ma & n	mai	catasa	tading	Interval Between Onset and Death			
	Medical Examiner		resulting in death)	L	ratary Lactur	0								
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as	conseque		ue he	av z	aller	ف ا				
	nted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	500 10 (5) 23	a conseque	inoc oij.								
	execuian and		that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):								
260	ate be executed physician and the burial-transit	edical		d										
687	certific nding passes as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	су				23d. Date of de	aliven			
Box 68	death (	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 4 Pregnant a			Ectopic pregnancy Other (specify)			Month	Day Year			
Ö.	at the od by th detach	, Phy	9 Unknown  Part II. Other significant condition		ut not resul	ting in the u	nderlying cause given in F	Part I.	23e. Did toba	cco use contribute to	o the cause of death?			
S, F	uires the signeral si	ed by	Sep.	cio					1 ☐ Yes	2 <b>√</b> No 3□F	Probably 4 🗆 Unknown			
Sorc	iw requ	plet	Sep- Eden	na.					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of			
Bec	sician: The law is certificate has kirector, page 2 s	Completed							performe	ed? death?	s 2 No			
ţ	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Othor	Death (Check	only one)					
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ouo	ath. r: Afte	ficat	1 Natural 5 ☐ Pendir 2 ☐ Accident Investi	gation	r, Year)	injury	work? M 1 ☐ Yes			,,				
Division of Vital Records, P.O.	I or Atte a after de Directo d in by th	27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined  28a. Date of injury (Month, Day, Year)  28b. Time of injury work? 1 Yes 2 No  28d. Describe how injury occurred												
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical E		xamination a	and/or investi	igation, in my opinion, dea	th occurred at	the time, date and	place, and due to the	cause(s) and manner stated.			
	To the within To the comple	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my F		29c. License numb	per	290	d. Date signed (Mont	h, Day, Year)			
	,		) Sju	nes	-		D508	70		Decembe	15th 2012			
	3/		30. Name and address of person		eath (Item 2	(3a) (Type, P	rint) And	un su	ite 2007	Colina	15th 2012			
	Stat Registra		31. Date filed (Month, Day, Year)  DEC 1	32. Pegistra		re L	200	U -						
	riegistic	٠.	ロドウェ	Jan Carre	W 1	7. D	The same of the sa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Physician/ Medical **Examiner** 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) **Funeral** Months Days **Director** 1 X M 2 70 July 10, 1942 Maryland Usual Residence of Deced show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. "item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at with the Maryland Director Glen Burnie Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 614 Wellham Avenue USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) City of Baltimore Caretaker O Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Mamie Ethel Krause Gordon Henry Purnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 614 Wellham Avenue, Glen Burnie, Maryland 21061 Linda G. Purnell (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ŏ Department of Important: If any injury or once. 12/14/12 Bayview Crematory, Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Maryland 21225-1856 M00175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CNCER disease or condition Medical resulting in death) Due to ( a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as signed by the attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Day Pregnant at time of death 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsv 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completely filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and ite 1023820 of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 31. Date filed (Month, Day, Year)

2RT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PEARL LORRAINE POTTER DECEMBER & Year Day 3.34Am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 218-18-8544 Director 1 M 2X F Maryland 88 Yrs Nov. 9, 1924 Usual Residence of Decedent show 10a. State 10b. County be notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Maryland Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 553 Riverside Drive Funeral 23a must k 21122 ıral", or items 2 I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa Specify: 3 Widowed 4 X Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse Solderer 10  $\Omega$ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Smith Eva Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Jeffries (Niece) 553 Riverside Drive, Pasadnena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 XBurial 2 Cremation 3 Removal from State Glen Haven Mem. Pk. 12/11/12 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Standara of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Kevin E Ecker 3204 Mountain Rd., Pasadena, Md. 21122 M00175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pauss on each line. Interval Between Immediate Cause (Final Onset and Death YHE Physician/ Monit disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Ectopic pregnancy ☐ Other (specify) ate has been signed by the atter page 2 should be detached for Pregnant at time of death 4 Pregnant : Month Dav Year 1 ☐ Yes 2 L 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 certificate. 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 \sum Yes 2 \sum No 5 Pending Investigation
6 Could not be filled in by the ☐ Accider☐ Suicide Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

DHMH 17 Rev 06-2011

State Registrar rive glen Burne mis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (

Registrar's Sign

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		-	For State Registrar	State of Mary		artment o rtificate o		Ĭ	giene 2 () Reg. No.	12	0000	
	Physicia Medi		1. Decedent's Name (First, Middle, La	reinia	Phillip	25		2. Date of De		Year	3. Time of Death 3:54 P M	
~	Examir		4a. Facility Name (if not institution, give	, — ,			, or Location of Death	h 4c. County of Death				
	Funeral		3931 E. Pratt 5. Social Security Number 6.5	Street  Gex 7. Age (In)	rs. last birthday)	If Under 1 Ye		8. Date of Bir			ace (State or Foreign	
	Director		346-52-0549 Usual Residence of Decedent	□ M 2 🗹 F	77 Yrs.	Months Day	ys Hours Min.	(Month, Da		Country	XIC	
	and show	tor	10a. State 10b. County	100	. City, Town or Lo	cation		11011	7 700	10	d. Inside City Limits	
	Mary 28a-f	Director	ms	13	Bal Lir	nore			<del></del>		1 ☑ Yes 2 ☐ No	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral L	3931 E. Prati	1 Street		10f. Zip Cod	21224		10g. Citizen of	What Countr	y?	
	r death or item liner m		11. Marital Status 1 ☐ Never Mamied 2 ☐ Mamied	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puert	pecify Yes or No- po Rican, etc.)	14. Rad Blad	ce - America ck, White, et		
5-0036	ırs afteı ıral", o IExam	ed by	3 ₩idowed 4 Divorced	1 Yes 2 You If Yes, Give Year or Dates.		1 ☐ Yes 2 🗹	No Specify:		Specify	Blac	K	
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	ld be filed Mental Hy larked oth atic event	To Be	17. Father's Name (First, Middle, Last)	/			/	me (First, Middle,		e)		
Maryland	should be and Ment Is marker		19a. Informant's Name/Relationship	Type, Print)/	19b. Mailii	na Address (Stre	et and Number or Ru		r City or Town S	State Zin Co	ide)	
	and 2 sh Health a em 27 ls ther tra		Sheila Phill	is Daughi	1 10-		ratt 5h	/ -	. /		1021224	
Baltimore	0 5 m		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Db. Place of Dispo cemetery, crer	natory or other p	olace)	Date	20c. Location	<i>,</i> '		
altin	4 F E F	1	4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice)	<u>" 17</u>	100 17	Carl  2. Name and Ad	me / /d-/ dress of Facility /a	13-2012 va hn C.	159/X	i MOI	services	
ä	Depar Impor any ir	1, 13	10081	201553	4	905 Y	ork Ro	012	. /		10012	
		5 5	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final		death. Do not ente	er the mode of o	tying, such as cardiad	or respiratory ar	rest,	1	Approximate Interval Between Onset and Death	
	Medical		disease or condition resulting in death)	a. Due to (or as a con	sequence of):							
	Examiner	-e	Sequentially list conditions,	b. Atri	al F	الحطة	-tion		_			
	rted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence oi):	Asto	ery I	io co	e			
	be executed ician and burial-transit	al Ex	that initiated events resulting in death) Last	Due to (or as a con	sequence of:	· -	<b>J</b>					
120	eath certificate be attending physic of for use as the b	ledic		d								
Box 68760	h certifi tending or use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre		Ectopic pregn	ancy		23d. Da	ate of deliver	y	
Bo	hat the deat ed by the att detached fo	Physician/Medic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify	)		Mo	onth D	ay Year	
P.O.	res that the signed by deta		Part II. Other significant conditions	contributing to death but no	t resulting in the u	ınderlying cause	given in Part I.	23e. Did to	obacco use cont	ribute to the	cause of death?	
rds,	requires been sig should b	eted									ubly 4 Unknown	
eco	The law i cate has b page 2 s	Completed by						24a. Was autoj perfo 1  Yes	psy	prior to com death?	sy findings available pletion of cause of	
al H	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?			26	. Place of Death (Che		2 A No	1 ☐ Yes 2	∐No	
f Vit	Physic this ce ral dire	유	1 ☐ Yes 2 No 27. Manner of Dath	Hospital:  1  Inpatient :  28a. Date of injury	2 ☐ ER/Outpatier 28b. Time of	nt 3 L DOA		lome 5 Resid				
o uc	nding ath. r: After re fune	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Yea	r) injury	W	njury at vork? ☐ Yes 2 ☐ No	28d. Describe h	now injury occurr	red		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate E within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the I	Certificate:	3 Suicide 6 Could not I 4 Homicide determined		At home, farm, str ecify)	eet, factory, office	ce	28f. Location (\$ City or Tox	Street and Numb vn, State)	er or Rural R	Poute Number,	
Ω	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	vsician: To the best of my k niner: On the basis of examin	nowledge, death	occurred at the t	time, date and place,	and due to the ca	ause(s) and man	ner as stated	I.	
	o the Pivithin 2 or the Fiomplet	Me	only one) 3 Certifying Nur 29b. Signature and title of certifier	se Practitioner: To the bes	of my knowledge	, death occurred	at the time, date and pense number	place, and due to t	the cause(s) and r	manner as sta	ated.	
			D- 003-64	edula	1 ms		02439	3	12/1	0/2	0121	
	HV		30. Name and address of person who	completed cause of death	Item 23a) (Type, F	pring) 56	, Balt	10, IM	D 2	12	211.	
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 1 2 2012	32. Registrar's S	hature face	1		<u>.</u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 3:30 AM M Joseph John Pivec Jr December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Nursing HOme Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 217-34-8289 1 🕅 M 2 🗆 F Mar 7, 1939 73 Maryland or items 23a or 28a-f show 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2X No Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 USA 203 Magnolia Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: white 'natural", 3 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 <u>bookbinder</u> publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph John Pivec Margaret Catherine Schmitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Magnolia Road Joppa, MD Doris Pivec/spouse Important: If item 27 21085 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ö injury 4X Donation 5 Other (Specify) a ure of Funeral Service any inj once. State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ( andi any p thy Onset and Death Physician/ achome ( disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Day Month Year Pregnant at time of death Unknown be detached Yes 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate has autopsy perform death? 1 Yes 2 No 1 Yes 21 Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?

1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 **To th**e I 29b. Signature and title 29d. Date signed (Month, Day, Year) D-38754. MP 12-04-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 21221 709. BASTERN WASBEM MALIKA

Registrar

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2012 ROSCOE 7:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 215-01-0851 1 M 2 X F 10-25-1918 Maryland 94 Usual Residence of Decedent 1 and 2 should be filed within 72 hours efter death with the Maryland of Health and Mentel Hygiene.
The sith and Mentel Hygiene.
The sith and 27 is merked other then "neturel", or items 23e or 28e-7 show other treumetic event, the Medical Evandrer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Elkridge Howard 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21075 6005 Virlona Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. 1 Never Married 2 Married <u>چ</u> Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h end Mentel F 7 is merked of မ Bartoch Helen Roman Kulczycki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 end 2 sh nt of Health e : If item 27 li Susan F. Kaniefski - daughter 2608 Franklinville Rd., Joppa, MD 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1 Depertment of Importent; If if eny Injury or o KX Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 12-10-2012 Brooklyn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Licar 21. Signature 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ enosTage DementiA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ettending physicien end I for use es the burlei-trensif that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>á</u> Records, lcate hes been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of 2 200 1 🗌 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific, completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D32279 Dicember 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

nsure All Copies Are Legible. th and Mental Hygiene

12-09274	Please Type or Print in Black Indelible Ink. Er
Gary Wayne Rose	State of Maryland / Department of Healt

		1- For State Certificate of Death Reg. No.											
Physicia ledical Exami	an/	1. Decedent's Name (First, Midd Ga	nry Wayn					]	Date of Deat Month December	Day Year 5, 2012	r	Time of Death	
		4a. Facility Name (if not instituti Baltimore Washingto			41	Glen Burnie	ocation of [	Death		4c. County of Anne Art			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 2	24Hrs. 8	3. Date of Birt	h(MM/DD/YYYY)	9. Birth; Foreign	place (State or	
Director		218-15-0254 Usual Residence of Decedent	1 X M 2 F	38	Yrs.	Mortano Bayo	Tiouro	141111.	09-23-	1974	Coun	try) MD	
any		10a. State 10b. County	,	10c. City, 1	Town or Location	n					1	0d. Inside City Limits	
Aaryland 28a-f show 1 at ouce.	5		Arundel				ambri	.11s				1 Yes 2 X No	
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 1409 Wigeon W	Iow #206			10f. Zip Code 210	5/.		10	og. Citizen of Who United			
with th ns 23a ne notii		11. Marital Status	12. Was De	ecedent Ever in U.S		Decedent of Hisp	anic Origin			14. Race	- America	n Indian, Black,	
Proposed to the proposed of th									can, etc.)	White Specify:		nite	
ours aft atural'	15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done division most of working life. DO NOT use retired)										siness/Inc	lustry	
)36 hin 72 h e. than "n	15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   16b. Kind of Business/in during most of working life. DO NOT use retired)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)   18. Mother's Name (First, Middle, Ma											n h	
d with ygiene of Med	E O	17. Father's Name (First, Middle											
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	Paul E. Rose,			Cart								
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	잍	19a. Informant's Name/Relation Eloise F. Ros		ber, City or Town									
e, N l and 2 Health litem 2												own, State	
Baltimore, permit. Pages lar Pepartment of Hec important: If ite		Meadowridge Mem Park 12-10-2012 Elkri										Maryland	
Balt permit. Departu Import injury		21. Si nat Te of Funeral Service Vicensee 22. Name and Address of Facility Gary L. Kaufman Funeral MMP, Inc., 7250 Wash. Blvd., Elkridge,											
Physician	-		or complications that	caused the death.								Approximate Interval Between Onset and	
/Medical		Immediate Cause (Final disease or condition resulting in death)  a. by Narcotic (morphine) Intoxication and Cocaine Use  Due to (or as a consequence of):											
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	9	a consequence of)	):								
ed sit	Exam	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of)	:						$\neg$		
/60, cate be executed physician and he burial - transit		X UNPENDED	d AMENDED	23a,27,28	8a-f,pe	r me,g93	5 1-1	7-13	sm		$\neg$		
760, ficate be ex g physician the burial	/Medical	IF FEMALE: 23b. Was decedent pregnant in		, outcome of pregn						23d. Date of			
Box 687  he death certification is the attending properties as the second contract of the s	cian	past 12 months?	Live	birth gnant at time of dea	ath	al death 3 are (Specify)	_Ectopic p	pregnanc	у	Month	Da	y Year	
Boy ne death r the att	Physician			nown					I oo an market				
b, P.O. Baires that the designed by the	ģ	Part II. Other significant cond	itions contributing	to death but not re-	suiting in the ur	iderlying cause giv	ven in Part	1.				e cause of death? bly 4 Unknown	
ords, w require is been si should b	Completed								24a. Was a			psy findings available mpletion of cause of	
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should t	d mo								perfor	med? d	eath?	2 No	
Vital Rec ysician: The B his certificate director, page	Be C	25. Was case referred to medical examiner?  1 Ves 2 No  25. Place of Death (Check only one)  1 Ves 2 No  1 Ves 2 N											
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ion of tending Pheath.	cation	1 Natural 5 Per	nding fd 1	th, Day,Year)	fd 10:3		es 2 🗶 N		nknown	, , , , ,			
10 2 0 5 S	Certifica	Investigation   Street and Number or Rural   Specify   Second of the determined   Specify									Route Number, City on Rd. #209		
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b													
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the car and manner stated.											
	Σ	29b Signature end title of certif	rier			29c. License O.C.N				29d. Date signe December	,		
		30. Name end address of person	n who completed ca	use of death (Item :	23a)	0.0.1					., 2012	1	
		Donna M. Vincenti, N	ID Assistant	Medical Exam	iner 900\	N. Baltimore	Street, B	Baltimo	re, MD 21	223			
9	tate 31. Date filed (Monte Cy. Year) 2012 32. Fegistrar's Signature fram												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:40 p 2012 Μ. Reid December Olive Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Baltimore</u> Futurecare Cherrywood Reisterstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 😿 F Months Hours Min. an 5, 1911 SC Country) 101 **Director** 095-18-9718 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State Funeral Director 1 Yes 2 No Owings Mills MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9500 Sidebrook Road 21117 U.S.A. Apt 509 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry ige 1 and 2 should be filed within 72 nt of Health and Mental Hygiene.

E: If item 27 is marked other than "reor other traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Berkley County Schools Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Feby Wilkins Joe1 Warren Richmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Olive Josephine Cruse Daughter Sidebrook Road Apt. 509 Owings Mills, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of Important: If it any injury or o Page 1 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/10/12 Carrol1 Hampstead, MD Cremation Signature of Funeral Service Licens 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Vascular 0000 disease or condition ) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed ohysician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death the page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 4 Jursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1. Natural injury 5  $\square$  Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Risterstown Rosel, Reisterstown

CRNP

12020

2. Registrar's Signature

Clarin

2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

December 10, 2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2012 7:30 PM OSEMAX Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death HUWARD COUNTY GENERAL COLUMBIA HOWARD COUNT If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) unk Director 578-52-0198 1 M 2 F Yrs. 71 Mar 27, 1941 23a or 28a-f show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Laurel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10617 White Rock Court 20723 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) unk unk permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mes Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard County General Hospital 5755 Cedar Lane Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 | Bunal 2 | Cremation 3 | Removal from State 4 | Donation 5 | Other (Specify) in state Signature of Funeral Service (Specify) | State Signature of Funeral Service (Specif 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore. ΜĎ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last ettending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No signed by the et I be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The lew require within 24 hours after death. To the Funeral Director. After this certificate has been sicompletely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 № No Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

ANIEUDH

2 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SRIDHARA

32. Registrar's Signature

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

29c. License number

20063164

CEDAR

29d. Date signed (Month, Day, Year)

COLUMBIA

2012

21044

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

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Ph	nysicia	n/	1. Decedent's Name (F		Last)								2. Date of Dea	ath	y 201	Year	3. Time of Death 0636 M	
do.	Medic xamin		Mary Yola 4a. Facility Name (if no		give street a	and numbe	r)		4b. City,	Town, or	Location o	f Death	Decembe	40	. County o	of Death		_
			13109 Tama		Road 6. Sex	17	Age (In yrs	last birthday)	Silv		princ		8. Date of Birt		ontgo		lace (State or Foreign	_
Dir	neral ector		017-48-132 Usual Residence of D	28	1 🗆 M 2		59	Yrs.	Months	Days	Hours	Min.	(Month, Da Dec 18	y, Year) , 19	52	Gount Myanr	trv)	
ıryland	led at	ctor		0b. County 10ntgo:	merv			ty, Town or Loc Jer Spr								1	0d. Inside City Limits 1 ☐ Yes 2X No	
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5-0036 2 hours after dea	rrai", or ite Examiner	ρ	<ul><li>11. Marital Status</li><li>1  Never Mamed</li><li>3  Widowed 4 </li></ul>		An 1 [	med Force Yes 2 Yes, Give ar or Dates	s? <b>K</b> No	If Yes, specify Cuban, Mexican, Puert							, White, e	etc.	i	
<b>Baltimore, Maryland 21213-0036</b> permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	than "nati	3 Widowed 4 Divorced Fear or Dates.  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  4  Director of Information Technology									Int	Business/Industry Information Sechnology						
De filed w	d other	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)											1097				
ould be	marke	-	Tze Choon Leong  Lian Ai Chen  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St.										ata Zin C	Code)	_			
nd 2 sho	m 27 is ner trau		Steven Hon-Keung So/husband 13109 Tamarack Road Silver Spring, MD 2															
Saltimore, bermit. Page 1 end Department of Hez	tant: If ite jury or oth		20a. Method of Disposition  20b. Place of Disposition (Name of Date cemetery, crematory or other place)											cion - City or Town, State				
Depart	any in		21. Signate of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. I Beverly L. Heckrotte, P.A. Clarksvi												Box ille	784 , MD 21029		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Carcinosarcoma of Lung											Approximate Interval Between Onset and Death 6 MONTHS						
	edical miner		Due to (or as a consequence of):  Metastatic Breast Cancer										1 year					
ted	ınsit	Examiner	Sequentially list condi- if any, leading to finite cause. Enter Underlyin Cause (Disease or inju-	ediate ng			es a nonsco Canco									1	1 years	
D be execu	pnysician and the burial-transit	edical Exa	that initiated events resulting in death) Las	st	c. —	Due to (or	as a consec	uence of):										
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BOX 68	the attend	Physician/M	23b. Was decedent pro in the past 12 mo 1 ☐ Yes 2 ☐ 1 9 ☐ Unknown	nths?	1 4	Live Bir	nt at time of	al death 3	Ectopic p Other (sp		<i>'</i>			İ	23d. Date Mon		ery Day Year	
S, P.O.	signed by	ρ	Part II. Other significa	ant condition	ns contribut	ing to deat	th but not re	sulting in the u	nderlying (	ause give	en in Part I						e cause of death?	
VITAI MECOFOS, ysician: The law requires	age 2 shou	Completed												osy ormed?	pr de	nor to con eath?	osy findings available impletion of cause of	
ician: T	ector, p	Be	25. Was case referred examiner?		Hospita	1.				-	ce of Deat	h (Check	1 L Yes	2 L.3kN	0 1	☐ Yes	2 LI NO	
O OT V ding Phys th.	Continue   Continue										)							
JIVISION al or Attendir s after death.	Cause (Disease or injury that initiated events resulting in death) Last    IF FEMALE:   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   23d. Date   1   Yes   2							or Rural	Route Number,									
Hospit	e runere pietely filk	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										use(s) and manner state	d.					
with #	100 FIOO		29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo. December 7)										*					
12.	,		30. Name and address Linda Bur			ed cause o	of death (Iter			#400	Whea	ton,	MD 209	02				
R	Stat egistra		31. Date filed (Month, I	Day, Year)	2012	3. Regi	strar's Signa	ature for	Ked									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year tthew 4:20 AM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 1 Year If Under 24 Hrs. The HOPKINS Hospita Johns 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 280-82-2540 Director 1 🗓 M 2 🗆 F Yrs Apr. 28, 1983 OH Usual Residence of Decedent end Mertel Hygiene. Is marked other than "natural", or items 23a or 28a-f ahow raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter deeth with the Meryland Director 1 Yes 2 X No VA Spotsylvania <u>Fredericksburg</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3221 Cavalry Ridge Court 22408 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None None B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည be Timothy Shultz Patricia Sullivan traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3221 Cavalry Ridge Ct., Fredericksburg, VA 22408 Mrs. Patricia Shultz (Mother) item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pega 1 e Depertment of H important: if ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 D Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation: 12/8/2012 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ intarction disease or condition resulting in death) Myocardial ; Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ete hes been signed by the ettending physicien end pega 2 should be deteched for usa es the buriel-trensit or Attending Physicien: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Marfan syndrome 1 ☐ Yes 2 ☐ No 3 🔯 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 🗆 No ours efter deeth. erei Director: After this certifice filled in by the funerei director, p 8 25. Was case referred to medical examiner? of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident М Investigation 6 ☐ Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours er To the Funeral Completely filled Medical 1 decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) MD ecember 7,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arendonk Kyle 1800 Orleans Street Battimore, Van MD 31. Date filed (Month, Day, Year) 82. Registrar's Signature State DEC 1 2 2012 back Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201<sup>Yea</sup> 2:36 December Frederick Schaub Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Hours Min (Month, Day, Year) Director 218-28-2081 1XXM 2 □ F 82 Maryland Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any mjury or other treumatic event, the Medical Examinar is ust be in third at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes ZYNo Marvland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 U.S.A. 128 W. Ring Factory Rd., Apt. 128 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. à 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 TNo Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Schaub Mathilda Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 W. Ring Factory Rd., Apt. 128 Bel Air MD 21014 <u>Juanita Schaub/Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/8/2012 Atlantic Crematory Glen Burnie MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, 610 W. MacPhail Rd., Bel Air MD 21014 Part 1. Enter the dise be, or one place in that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lin only one cause on each line. Approximate Interval Betweer nellmono Immediate Cause (Fire Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the attending physician and the for use es the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 줊 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) ᅙ 1 Yes 2/1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pending 1 Yes 2 No М Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1, 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hour 00 63220 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHESALEAUC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

TOD: 14

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	Physicia Medic		Dorothy Anne Sproul					2. Date of De Month		Day 2	Year 20/2	3. Time of Death	
)	Examin		4a. Facility Name (if not institution, give street and number) Charlestown Care Center	Ca	City, Town, o	ille				4c. County			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthde $056-01-1896$ 1 $\square$ M 2 $\raisebox{12pt}{$\stackrel{\times}{\mathbb L}$}$ F $98$ Yrs	Mont s.	nder 1 Year ths Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da 2/13/	ay, Year		Court	place (State or Foreign try) Jersey	
	e Maryland r 28a-f she notified al	Funeral Director	10a. State 10b. County 10c. City, Town or MD Baltimore Catonsv	ille	•							0d. Inside City Limits 1 ☐ Yes 2 XNo	
	with the 23a of	eral	709 Maiden Choice Lane, RGS 230		. Zip Code 1228					S.A.	What Cour	ntry?	
9200-61212	filed within 72 hours after death with the Maryland Hygiene. Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ξ	Armod Forces?	If Yes, s	ecedent of H specify Cuba s 2 X No	n, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			etc.	
2	72 hou in "nat Medica	Completed	(Specify only highest grade completed) (Gi	ive kind of	Jsual Occup work done o use retired)		of workin	g	16b.	Kind of B	usiness/In	dustry	
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	1 and 2 should b of Health and Mer item 27 Is mark other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. M Barbara Lawrence/Daughter 740	ailing Addi 4 Fro	ress (Street a	and Number <b>d Cir</b>	r or Rural cle,	Route Numbe	r, City	or Town, S ID 20	State, Zip ( 707	Code)	
baltimore,	permit. Page 1 and 2 s Department of Health s Important: If item 27 any injury or other tra once.		20a. Method of Disposition  1	rematory of	or other plac	e) V	12/1	ate 1/2012			- City or To		
Dall	permit. Departi Import any inj once.		21. Signature of Funeral Service Licensee	22. Name	and Addres	ss of Facility	Ste	rling / onsvil. Cator	Aght	ton S	chwał	Witzke	
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3	Attending Friystoan: The law requires that the death certificate be executed and after this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner											
. DOY 00	requires that the death certific been signed by the attending should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 3 9 ☐ Unknown	3		у				23 <b>d</b> . Dai	te of delive	ery Day <b>Y</b> ear	
J.L. CD	quires that en signed k	þ	Part II. Other significant conditions contributing to death but not resulting in th	e un <b>d</b> erlyir	ng cause giv	en in Part I.						e cause of death?	
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N .	rnysician: this certific ral director,	To Be	examiner?  1	tient 3 🗆	Othe	ace of Death		only one) ne 5 🗆 Resid	dence	6 □ Oth∈	er (Specify)		
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	o the nospital of Attendi within 24 hours after death.  To the Funeral Director; A completely filled in by the fi		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)				4	City or Tow	n, Stat	re)		Route Number,	
	vithin 24 hours after to the Funeral Dir.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or involved only one) 3 Certifying Nurse Practitioner: To the best of my knowled	estigation,	in my opinio	n, <b>d</b> eath occ	curred at the	ne time, date a	nd plac	e, and due	to the cau	se(s) and manner stated	
ļ.	No thir To this COTTIP	2	29b. Signature and title of certifier	2	29c. License	number			29d. D.	ate signed	d (Month, E	ay, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type	2	D44	377			12	181	12	2.270	
			Deneen Bowlin, mp 711 Maid	en (	Maio	0 6	i he	Cato	875	vill	e, n	21228	
¥	State Registra	_	31. Date filed (Month, Day, Year)  DEC 1 2 2012  32. Registrar's gignature.	2				11			,		
_													

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:22PM pcema John Edward Sroka Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Town, or Location of Death Minore 0 2 0 Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Month, Day, Year) Director 217-38-9400 1 x M 2 ☐ F 73 Sept 16, Maryland 10a, State 10b. County Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examinar mant be mortified at 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No MD Baltimore Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9225 Wrights Mill Road 21163 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White 3 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 7 and Mental Hygiene, 8 marked other than Elementary/Secondary (0-12) United States College (1-4 or 5+) Fitter Coast Guard Pipe Yard Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Sroka Winkler Loretta permit. Page 1 and 2 should Department of Heelth and Me Important: If Item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) atrect Constance Sroka Wife 9225 Wrights Mill Road Woodstock, Maryland 21163 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/13/12 View Mem. Park Sykesville, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 6 slan Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the deeth certificate be executed Cause (Disease or injury attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Certificate: To 1 Yes Other: npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred latural 2 Accident 5 Pending iniury 1 Yes 2 No Director: A Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours after

To the Funeral Direct

completely filled in b City or Town, State Medical TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) xighs in 31. Date filed (Month, Day, Year 32 Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AM Journey Scott 00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death R 050 ranklin da 01 more uase Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢 F Hours 2 DEC 2 Day, 2012 13 Maryland Director infant Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2x No MD Baltimore Baltimore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 7401 Waymouth Way 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Yes 2 X No þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: and Mental Hygiene. is marked other than "natural", Specify: black 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) infant infant infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Scott Latoya Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Franklin Square Hospital 9000 Franklin Square Drive Rosedale, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Durial 2 Cremation 3 Removal from State 4 □ Donation 5 💢 Other (Specify) in state Rona I o Licensee S V W 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ matus disease or condition me Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errer Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death detached 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed ge 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law has autopsy performed? 1 ☑ Yes 2 ☐ No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Al 1 Yes 2 No Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of

Basma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Journe

🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Franklinsquare Drive

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Baltimore

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10b per fit g934 12 12 12 12 12 Wental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12 Month 0 6 Day 2012 Year Physician/ 15:33PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Memorial Baltimore Inion If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Director 1 □ M 2 💢 F Yrs 26 and Mentai Hygiane.
I is merked other then "neturel", or itams 23e or 28a-f ehow
raumatic event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filad within 72 hours efter death with the Meryland N/A **Funeral Director** Baltimore 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA 33rd Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Specify: African ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Johns Hopkins Cashier 12thorade Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alma Ragicund M. Sanford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Vones Stream Handallstown MD other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 12/13/2012 Woodlawn, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 8728 Liberty Road Plandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician MYOCARD NEARLTION 48hrs Medical Due to (or as a consequence of): Examiner 48 hrs neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physicien and id be deteched for use es the burial-trensit Hospitei or Attending Physicien: The law requires that the daeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed To the Hospitel or Attending Physicien: The law requires within 24 hours after death.

To the Funerel Director: After this certificete has been si completaly filled in by the funeral director, paga 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 12/6/12 2435946

State Registrar 1 all

KAVITA KAKKAD 31. Date filed (Month, Day Year)
DEC 1 2 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MEDSTAR UNION MEMORIAL HOSPITAL 201 EAST UNIVERSITY PARKWAY BALTIMORE 21218 MD

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mille Ann Trice 2:10A M 2012 Medical december 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchnst Hospice IOWSON Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 215.52.2831 Hours (Month, Day, Year) Director 1 M 2 XF MD 03 21 1949 or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itams 23a or 28a-f sho traumatic avant, the Medical Examinar must be notified at Director Baltmore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5404 quen ue 21215 Lynview USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, 1 Never Married 2 Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc. δ Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Paga 1 and 2 should be filed within 72 ment of Health and Mental Hygiana. ant: If itam 27 Is marked othar than 'ury or other traumatic avant, the Me College (1-4 or 5+) Elementary/Secondary (0-12) School Nusina 12th grade Be 17. Father's Name First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ Copeland Willis W. Darden Virgio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice D. Trice Camberwell Court Windsor Mill MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State parmit. Paga 1 a
Department of H
Important: If ita
any injury or ot Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1215/2012 4 Donation 5 Other (Specify) Noodawn Cemetery Woodlawn, MD Vaudm C. Greene Funcial Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart ailure. List only one cause on each line. Approximate Interval Between Dnset and Death Immediate Caus (Pinal Physician/ disease or condition reference Browst Co Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attanding physician and I for use as the burlal-transit The law requires that tha death cartificate ba executed Exal resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day ata has been signed by the a paga 2 should ba datached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attanding Physician: The within 24 hours after death.

To tha Funaral Diractor: After this certificata I 1 ☐ Yes 2 ☐ No funaral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗆 Yes 1 Inpatient 2 ER/Dutpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be tha ☐ Accident ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier complately (Check 3/ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RATHI KUMAR 31. Date filed (Month, Day, Year) ... 32. State gistrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Atrium Court, Apt. 240 Owings Mills
If Under 1 Year Wunder 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral 30.9798 Director 1 X M 2 □ F MO 07 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show eny Injury or other traumatic event, the Mcclical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director Owings Mills 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4730 Atrium USA 2117 Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Armed Forces?

1 No If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Amicar Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Architecture Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Howard Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia EVans Road Detroit (NIECE) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cremation Center 2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vallann C. Greene There Sorvices 21. Signature of Funeral Service Licensee Rond Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UNC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospitalior Attending Physicien: The law requires that the death certificate be executed within 24 hours effer det.th.

To the Funerel Director After this certificate has been signed by the ettending physicien and for use es the burial-transi Cause (Disease or injury ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 2 No 1 Yes Yes ours after decth.

erel Director After this certification by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the be of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 V

DHMH 17 Rev 06-2011

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Renee Fise Thomas State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day December 4, 2012 Year 0544 hrs Medical Examiner 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Loch Raven Boulevard at Deanwood Road Parkville If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5 Social Security Number 6 Sex **Funeral** Foreign Months Days Hours Country)/91/27/W Director М Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho must be notified at once. Director 10g, Citizen of What Country? 10f. Zip Code 10e Street and Numbe HARSIDEN/ ASEN, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Never Married 2 No Yes f Yes, Give Year Yes 2 No specify: 3 Widowed 4 Divorced 2 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Unk WINK 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Δate 20c. Location - City or Town, State Baltimore, crematory or otherplace) or other 2 Cremation 3 1 Burial Removal from State portant: 4 Donation 5 Other Specify 21. Signatur of Funeral Service I cen-22. Name and Address of Facility 23a. Ray I. Into the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Retween Onset and failure. List only one cause on each line (Medical Death e. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause ase or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial Hospital or Attending Physician: The law requires that the death certificate be of Vital Records, P.O. Box 68760, IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) isigned by the atte 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been s funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? 2 No ✓ Yes 2 No **V** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 Yes 2 No 28a. Date of Injury FOUND: Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Pedestrian struck by auto FOUND: Division Natural 1 Yes 2 ✔ No Pending death. To the Funeral Director: completely filled in by the Dec 4, 2012 0539 hrs 2 🗸 Accident Investigation Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Loch Raven Boulevard at Deanwood Road, Parkville, M determined (Specify) Local Street Homicide 29a. Certifier 1 (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number December 4, 2012 O.C.M.E. Must 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio M.D., Ph. D.

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registra 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2012 December 0954 Paul Kingsbury Van der Slice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery 9121 Kirkdale Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. (Month, Day, Year) or 14, 1935 Months Hours Pennsylvania **Director** 579-48-5020 1 X M 2 □ F 77 Yrs Usual Residence of Deced 28a-f shov 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Bethesda 1 Tes 2 No MD Montgomery 10e. Street and Numbe 10f. Zip Code 'n 10g. Citizen of What Country? USA Funeral 23a 20817 9121 Kirkdale Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ral", or iter Examiner 14. Race - American Indian. Armed Forces þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the History Professor College 5+ t of Health and Mental Hygi If item 27 is marked other or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Austin Van der Slice Hope Kingsbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Goldberg Van der 9121 Kirkdale Road Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State ō 1 🗌 Burial 2 🔀 Cremation 3 🗎 Removal from State Department of Important: If any injury or once. Final Journey Crematory 12/12/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service MO1251 Reverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. rval Betweer nset and Death hours Immediate Cause (Final Physician! disease or condition resulting in death) Stroke Medical Due to (or as a consequence of): Examiner Myelodysplastic Syndrome Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) if or Attending Physician: The law requires that the death certificate be executed after death.

Director After this certificate has been signed by the attending physician and burial-transit resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy be detached for in the past 12 months? Month Year Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be director, page 2 s autopsy performed' 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\blacksquare$  Residence 6  $\square$  Other (Specify) ٥ 1 Tes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 8c. Injury at 28b. Time of 5 🗆 Pending 1 Natural work?
1 Yes 2 No Investigation Accident filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Funeral I Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Yea December 11, 2012 D23308

DHMH 17 Rev 06-2011

State Registrar

201

Victor M. Priego, M.D. 6410 Rockledge Dr #660 Bethesda, MD 20817

82. Registrar's Signature

30. Name and address of persor who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Carmen Rosita Verleysen Medical 0920 2012 December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5116 Bonnie Brae Court Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Oct 18, **Director** 200-60-3255 88 1 □ M 2 X F Japan Vrc Usual Residence of Deced shov 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Howard Ellicott City 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 9 ritems 23a or ner must be n 10g. Citizen of What Country? Funeral 5116 Bonnie Brae Court 21043 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? "natural", or i Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 Yes. Give 1 ☐ Yes 2X No Specify. Specify: White 3 XWidowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 other Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked or ည Juan Planas Kin Mitsuhashi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5116 Bonnie Brae Court Ellicott City, MD 21043 Health em 27 Pierre A. Verleysen/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or of Page 1 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/13/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate 23a. Part 1. Enter the prease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Aortic Valve Discaso disease or condition Medical resulting in death) Due to (or as a consequence o **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Transient Ischemic Attack Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical certificate be 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy Po in the past 12 months? Month Day Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 X No Yes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of e Hospital or Attending P 124 hours after death. e Funeral Director: After t After t 28d. Describe how injury occurred 1 X Natural 5 Pending injury Division Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the the only one To the within To the 29c. License number 29d. Date signed (Month, Day, Year) D28921 December 11, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Imtiaz H. Chowdhry,

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

10792 Hickory Ridge Rd. Columbia, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dec. 2012 7:40P Physician/ Darwin Lewis Wood Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Carroll Sykesville Fairhaven Health Care Center 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Year If Under 24 Hrs. July 21, **Funeral** Months 199-16-3688 91 Director 1**X** M 2 □ F NJ Yrs. Usual Residence of Decede 10d. Inside City Limits 28a-f shov 10c. City, Town or Location items 23a or 28a-f sho her must be notified at 10a. State filed within 72 hours after death with the Maryland Director Sykesville 1 Yes 2X No Carrol1 MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21784 C - 1087200 Third Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. er than "natural", or iter the Medical Examiner Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic College (1-4 or 5+) Elementary/Secondary (0-12) Laboratory Physicist Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sarah Cook ပ Wood Ernest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7200 Third Avenue C-108, Sykesville, MD 21784 Mrs. Gertrude L. Wood (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State All County Cremation | 12/7/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Signature of Funeral Service License PO Box 195 Sykesville, MD 21784 M00764 Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Ogset and Death Immediate Cause (Final Physician neumono disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions Examiner in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? fibrillation 24a. Was an autopsy certificate has performed' 1 🗌 Yes 2 🗎 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) မြ After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: injury 5 Pending 1 Atural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completely filled in by the f ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29c. License number 34849

101 State Registrar

31. Date filed (Month, Day, Year)

1645 Libert TanMD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Road Eldersburg MD

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40074 State of Maryland / Department of Health and Mental Hygiene 20 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1104 AM Rettie V Wehlar DEC 2019 10 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Howard Columbia Howard County General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Country) Director 215-32-9416 1 □ M 2 🛣 F 78 07/04/1934 WV Usual Residence of Decede 10d. Inside City Limits shov 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after daath with the Maryland er than "natural", or Itams 23a or 28a-f sho Director 1 Yes 2 XNo New Windsor Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21776 2785 Miles Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married Yes 2 No ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White If Yes, Give 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education permit. Page 1 and 2 should be filed within 72 h Deportment of Health and Mental Hygiana. Important: If item 27 is marked other than "n: any injury or other traumatic event, If a Mealis once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Dept. of Social Elementary/Secondary (0-12) College (1-4 or 5+) Services - St. of MD Case Worker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Lillie Susan Barr Alvin Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9412 Guilford Road Columbia, MD Marissa J. Miller - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/13/12 Columbia, MD Christ Episcopal Cem. : 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee Show 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonia DAYS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate After this certificate has been signed by the attending physicien and strunaral director, page 2 should be detached for usa es the burial-transit To the Hospital or Attending Physician: Tha law requires that the daath certificata be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 month Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2 No 1 ☐ Yes 2 🚾 No 25. Was case referred to medical 26. Place of Death (Check only one) B Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) 2 No 1 Tyes Inpatient 2 ER/Outpatient 3 DOA မှု 28a. Date of injury (Month, Day, Year) erel Director: After thi 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funerel D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 74554 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21044 5755 Cedar Lane Columbia, MD Zesham Ahmed Rajput, MD 31. Date filed (Month, Day, Year) **DEC 1 2** 32 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 45PM 2012 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** A Hicorre enera 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number **Funeral** Min 3 Months Hours (Month, Day, 216-78-7764 5 Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at with the Maryland Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5. 21229 808 er than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates amma Watkin 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry is marked other than aumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) usmotolu9 12 Be 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number her City or Town, State, Zip Codel Department of Health ar Important: If item 27 is any injury or other trauonce. Johnson 808 500 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place. -15-2012 13 u l 4 Donation 5 Other (Specify) 21. Signal re f Funeral Service Licensee 170 Ba 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Year Pregnant at time of death 5 Other (specify) signed by the at the detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 L Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 🗶 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, 2× No 1 ⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) this Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director; After eted filled in by the funer 1 🗷 Natural injury work? 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Depth of Internal Medicine, 827 Linden avenue, Baltimore Sharma 31. Date filed (Month, Day, Year) 32. Registrar's State DEC 1 2 2012

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Z For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WINIARSKI DECEMBER 9 VIRGINIA 2012 Physician/ J. 7:25 A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE STELLA MARIS HOPICE CENTER TIMONIUM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-22-1944 83 yrs 2-17-1929 MARYLAND Director 1 ☐ M 2 🛣 F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumafte event, the Medical Examiner must be notified at any injury or other traumafte event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director ROSEDALE 1 🗆 Yes 2 No BALTIMORE MD 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number U.S.A. Funeral 21237 938 ROSEDALE AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛛 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes. Give Completed 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) DOXEE COMPANY SECRETARY Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EVE VIRGINIA CORD MAHLON CLOUD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BROTHER 940 ROSEDALE AVENUE ROSEDALE, MD CHARLES R. WINIARSKI/ IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State METRO CREMATORY 12-11-12 CATONSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Algnature of Funeral Service License ROSEDALE, MD 21237 1211 CHESACO AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RENAL DISEASE Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last eral Director. After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 2 X No 1 Inpatient 2 ER/Outpatient 3 DDA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

VIRGINIA WINIARSKI Hospital or Attending Physician: Division of Vital after death Director: 24 hours a Funeral L

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Medical within 24 hound to the function of the functin of the function of the function of the function of the function the

JONES, JACKIE 31. Date filed (Month, Dav. Year) State Registrar

29b. Signature and Itle of contifier

29a. Certifier

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Mention Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

(ی

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **CECELIA** WILLNER DECEMBER 2012 EMELINE 5:30 A 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death BALTIMORE TOWSON GILCHRIST HOSPICE FACILITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number (Month, Day, Year) Days Hours 215-24-3808 90 yrs. 1 □ M 212 F MARYLAND 6-24-1922 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1X Yes 2 No BALTIMORE N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21230 801 KEY HIGHWAY Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify WHITE 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ZINKAND BAUM CECELIA **JAMES** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 801 KEY HIGHWAY BALTIMORE, MD 21230 JOAN A. BIRMINGHAM/DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ₩XBurial 2 ☐ Cremation 3 ☐ Removal from State MIDDLE RIVER, MD HOLLY HILL MEMORIAL 12-14-12 4 Donation 5 Other (Specify) CVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service Licensee 22. Name and Address of Facility ROSEDALE, MD 21237 1211 CHESACO AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CLONIC MILA

Physician Medica Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examine 24 hours after death. After this certificate has been signed by the attending physician and a Funeral Director. After this certificate has been signed by the attending physician and lately filled in by the funeral director, page 2 should be detached for use as the buriel-transit Certificate: To Be Completed by Physician/Medical

Medical

only one)

29b. Signature and title of certifier

Nany

or Attending Physician: The lew requires that the death certificate be executed

Hospital

To the Hosp within 24 hor To the Fune completely fi

Division of Vital Records, P.O. Box 68760

disease of condition	- a - ) (				
resulting in death)	Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):				
that initiated events resulting in death) Last	c. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year			
Part II. Other significant conditions		accouse contribute to the cause of death? as >> ☑ No 3 ☐ Probably 4 ☐ Unknow			
	24a. Was ar autops perforn 1 □ Yes 2	y prior to completion of cause of death?			
25. Was case referred to medical	26. Place of Death (Check only one)				
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Reside	nce 6 Other (Specify) WOSOLD			
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat		w injury occurred			
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier Certifying Pl	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cau	se(s) and manner as stated.			

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ucritiying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2012

State Registrar s of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 4 **Physician** Samuel James Weaver /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GENESIS BALTIMORE MANOR CATON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Maryland Mar 21, 1942 70 212-40-3978 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 1√ Yes 2 No MD Curtis Bay Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4218 Morrison Court 21226 USA 14. Race - American Indian, by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) residential 6 0 carpentry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Monroe Weaver Ruth Tawnev ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau Ruth Gardner/daughter 185 Old State Road Lot #73 Broadalbin, NY 12025 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Serve Licensee Director Baltimore, MD Board 655 W. Baltimroe Street 23a. Part \( \) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CANCER Immediate Cause (Final EEW MINTE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending 1 🗌 Yes 2 🗌 No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of oprtifier D0062634 Dec 4, 2012 MO 30. Name and a press of person who completed cause of death (Item 23a) (Type, Print) HICKORY Ridge Rd COLUMBIA MOZINY

Registrar DHMH 17 Rev 1/2001

State

MATEEN

31. Date filed (Month, Day, DEC 1 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Josephine Frances Yuhanek 11:15 P Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pickersgill Nursing Home Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Davs (Month, Day, Yea 07–24–1921 Months Hours Min. <sup>Country)</sup> Mary Land Director 213-16-4541 91 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 2202 Pinehill Farms Lane 21030 U.S.A. items 11 Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. "natural", or iter Armed Forces 1 Never Married 2 Married 1 Yes 2 K No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. Processor Federal Reserve Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James A. Weber Frances C. Krolczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Fleischer (daughter) 2202 Pinehill Farms Lane Cockeysville, Md 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1  $\stackrel{K}{\boxtimes}$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 12-13-2012 Brooklyn Park, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Ashley Kelley 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland M01682 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition Medical resulting in death) Due to (or as a consequend of) Examiner DE Sequentially list conditions, if any, leading to immediate cause. Enter uncerning Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypothyroid 24a. Was an has autopsy nerformed 24 hours after death. Funeral Director: After this certificate 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 2 Accident injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ewon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

2 2012

32. Registrar's Signature

4105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 10:55AM<sup>M</sup> <u>November</u> Brenda Lee Anders Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 350 Hollingsworth Manor Road <u>Elkton</u> If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth . Age (In vrs. last birthdav) Social Security Number **Funeral** Months Days Hours Min (Month, Day, Year 1 M 2 TF 227-98-5561 48 Yrs **Director** 1964 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes XX No Maryland Ceci1 E1kton ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 350 Hollingsworth Manor 21921 Road 15 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important, If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) q Food Service Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Floyd Dee Roberts Carol Elizabeth Rankin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodger B. Anders / Spouse β50 Hollingsworth Manor, Road 15, Elkton, Maryland21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November North East United Methodist Cemetery 1XXBurial 2 Cremation 3 Removal from State 28, 2012 ☐ Donation 5 ☐ Other (Specify) North East, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Crouch Funeral Home, P.A. U. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or shock, or heart failure. List only somplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, iner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequent Exami or Attending Physician: The law requires that the death certificate be executed monic Kidae attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 9 Unknown the page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifies completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work 1  $\square$  Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/26/12

State Registrar 31. Date filed

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OKSOU

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #20b-c Per FH State of Maryland / Department of Health and Mental Hygiene 6/2012 AACO HEALTH DEPT. CMH Certificate of Death Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:10 A M 2012 TONEY JEROME AUSTIN NOVEMBER Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Country) 217-56-3886 **Director** 61 1 X M 2 □ F MARYLAND 4/12/1951 Usual Residence of Decede 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director ANNAPOLIS 1 Yes 2 No MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 21401 1906 LINCOLN DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: AFRICAN AMERICAN 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed Year or Dates. ARMY 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MOVING 12 MOVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EDITH WILLIAMS EUGENE AUSTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5359 COLUMBIA RD. APT. B COLUMBIA, MD 21044 TROY LEE AUSTIN/ SON 20b. Place of Disposition (Name of L. PARK 20a. Method of Disposition 20c Location - City or Town, State ANNAPOLIS, MD permit. Page 1 a
Department of H
Important: If ite
any Injury or ot
once. 12/5/2012 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
CROWNSYTLLE VETERANS
CEMETERY 11/29/2012 CROWNSVILLE. 22. Name and Address of Facility LASTING TRIBUTES BY FELLOW: ELFENBEIN & NEWNAM CREMATION & FUNERAL CAING BESTGATE RD. ANNAPOLIS MD 21401 21. Signature of Funeral Service Licensee Wallaco 9 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line. the or respiratory arrest. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ò in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably Unknown been sig Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b lirector, page 2 s autopsy performed death? 1 ☐ Yes 2 ☐ No director, or Attending Physician: **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှု 1 Inpatient 2 ER/Outpatient 3 IDOA n 24 hours after death.

The Funeral Director: After this pletely filled in by the funeral di this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical 29a. Certified To the Hosp within 24 hor To the Fune completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signatu

and title of certified

26 201

31. Date filed Month, Day, Year)

completed cause of death (Item 23a) (Type, Print MD

d (Month Day, Year)

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29d. Date sign

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	1 - For State Registrar		•	•	nt of Heal te of Dea			Reg. No. 2	0/2	4008
cian	1. Decedent's Name <i>(First, Middle, L</i> ast Emma Marie A						2. Date of De		Year	3. Time of Death 12:58 a
ical ner	4a. Facility Name (If not institution, give				Town, or Loca		-		nty of Death	
al or	5. Social Security Number 6. Se	x 7. Age	(In yrs. last birth		r1 Year If U	nder 24 Hrs. ours Min.	8. Date of Bir (Month, Da 03/31/	th 1, Yea <i>r)</i> 1,928	9. Birthp Cour Mary	lace (State or For try) Land
	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town						1	0d. Inside City Lin
ecto	MD Wicomico Salisbury  10e. Street and Number 10f. Zip Cor							10g. Citizen o	of What Cour	1 ☐ Yes 2 😿
ğ	10e. Street and Number 7851 N. West Road		21801			JSA	iu y :			
by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 []Yes 2 [N If Yes, Give Year or Dates:		13. Was Dece	edent of Hispan ecify Cuban, Me	ic Origin? (Spexican, Puerto	ecify Yes or No Rican, etc.)	- 14. R	ace - Americ	etc.
Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5-		Decedent's Usi (Give kind of w life. DO NOT i Cook	ork done during	most of work	ing	16b. Kind of Business/Industry  Hospital		
Be C	17. Father's Name (First, Middle, Last)						e (First, Middle	, Maiden Surn	ame)	
2	Avery Shockley		1 401				hillips	Oits T	Otata Zia	Code
	19a. Informant's Name/Relationship (T) Wilbur Albert Aust						al Route Numb $21 { m mar}$ ,			Code)
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ f 4 ☐ Donation 5 ☐ Other (Specify,		cemetery	Disposition (Na , crematory or hill Me	other place)	1	Date 6/2012	20c. Locatio	-	wn, State
	21. Signature of Funeral Service Licens	<del></del>	,		and Address of I		13 E G	Grove S	t,Delm	nar,DE 1
dical Examiner	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown								Date of deliv Month	ery Day Yea
by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use con									
Completed							1 □ Yes	psy ormed? 2 No		opsy findings avai impletion of caus
o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Out	tpatient 3 ☐ E	Other:		h (Check only one 5 Nes		Other (Speci	fv)
шыл	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	ry 28b. T		28c. Injury at Work? 1 ☐ Yes		28d. Describe		<del></del>	,,
Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ury - At home, far c. (Specify)	m, street, facto	ry, office		28f. Location ( City or To	tion (Street and Number or Rural Route Number, or Town, State)		
ledical	29a. Certifier 1 Certifying Phyone) 1 Medical Exam	ysician: To the best of iner: On the basis of and manner sta	f examination and	, death occurre d/or investigation	ed at the time, don, in my opinio	late and place n, death occu	, and due to the rred at the time	e cause(s) and , date and place	manner as ce, and due t	stated. o the cause(s)
Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month)									Day, Year)
1	30. Name and address of person who c	completed cause of de	eath (Item 23a) (	Type Print)		*	m		+	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #21 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registra Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 ALFRED LYLE ADCOCK 10 9:30 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1515 BREHM ROAD WESTMINSTER CARROLL 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Days Hours Min. Country) Director 5/12/1938 <u>216-36-0226</u> VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1515 BREHM ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 XXNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. WHITE 3 Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION SELF-EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ FANNIE JOHNS LEMON ADCOCK 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY COLE/ FIANCEE 1515 BREHM ROAD, WESTMINSTER, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION 10/22/2012 HAMPSTEAD, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Fac PRITTS FUNERAL 412 WASHINGTON HOME AND CHAPEL ROAD, WESTMINSTER MARK MORRISON, PER DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician a. VENTRICULAR ARRHYTHMIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ONE HOUR PULMONARY HYPERTENSION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed TWO YEARS SILICOSIS attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Year Pregnant at time of death 4 Pregnant cate has been signed by the page 2 should be detached g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2XX No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2X certificate Be 25. Was case referred to medical examiner?
1 ☐ Yes 2 🏋 No director, 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) Hospital: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 X Natural injury work? 5 Pending 2 No Accident
Suicide Investigation 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/17/2012 D27211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 6190 GEORGETOWN BLVD, ELDERSBURG, MD 21784 STEVEN BILLET, 31. Date filed (Month, Day, Year) State DEC 1 Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate of	Death		Reg. No.	12	40084
ı	Di		1. Decedent's Name (First, Middle,					-	2. Date of De	To-m	Year	3. Time of Death
	Physic /Medi		Patricia	pro	deric	K			Nove	mber 26	2012	4:00 AM
	Exami		4a. Facility Name (If not institution,	give street and numb	ber)			4b. City, Town, or Lo	ocation of Deat	,		
			Villa Rosa				WM de d V	Mitchellvi			e Geor	×
1	Funeral Director		015-22-7502	. Sex 7. 1□M 2□F	. Age (In yrs. lasi	t birthday) Yrs.	Months Days		8. Date of Bir (Month, Da Sept 1	rth ay, Year) 7 <b>,1</b> 928	9. Birthp Coun Mass	lace (State or Foreign try)
	and *		Usual Residence of Decedent  10a. State 10b. County		10c City T	own or Loc	ation				11	Od. Inside City Limits
	Aaryla F sho	5		George's	100. 01.9, 1		Marlboro					1 ☐ Yes 2 ☐ No
	the 1286	Director	10e. Street and Number	ocorge B		opper	10f. Zip Code			10g. Citizen of	What Coun	
	3e or		4716 Colonel Dar	nell Place			2077	79		United S		
	death	Funeral	11. Marital Status	12. Was Deced	ent Ever in U,S.				ecify Yes or No		ce - Americ	
Baltimore, Maryland 21215-0020	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "netural", or Items 23e or 28e-f show event, the Medical Exertiner must be inclifted at	δ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Date	₹No				Hican, etc.)		ck, White, o	
5-0	72 h	etec	15. Decedent's (Specify only highest)	Education grede completed)	1	(Give k	nt's Usual Occu	during most of work	ing	16b. Kind of B	usiness/Inc	lustry
121	vithin hen "	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life. Do	O NOT use retire	ed)	•	Dorde	Counto	
2	Hygi Hygi nt,		12 17. Father's Name (First, Middle, La	ct)		Nati	ıralist	18. Mother's Name	e /Eiret Middle		Servic	e
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ary.	d 2 should th and Mer 7 Is marke traumatic	٦ ر	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Stree	t and Number or Run	- ,	er, City or Town,	. State. Zip	Code)
Š	42 d 2		Thomas Broderick	(Husband)		_		arnell Place		_		
e,	S = = 0		20a. Method of Disposition	o ha come of the		e of Disposi	tion (Name of tory or other pla		Date	20c. Location	- City or To	wn, State
Ē	Pages nent of I int: If ite		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ate	Cremato			Nov 27 2	012 Clin	ton M	D
alt	pemit. Page Department of Importent: If any injury or once.		21. Signatur of Funeral Service Lic	ensee				ess of Facility Lee	Funeral	Home Inc	6633 0	ld Alexandria
<b>m</b>	895 5 8		John Xkel	mo	71391	Fer	ry Road,	Clinton, MD	20735			
			23a. Party. Enter the disease, or co shock, or heart failure. List on	mplications that cau	sed the death. [	Do not enter	the mode of dyi	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
-	Physician				,	_						Onset and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Asp	matic	20	gneu	ainom				
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	uted d ansit	Examiner	B Sequentially list conditions.  Due to (or as a consequence of):									
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39 ×	certificate be executed Iding physician and Ise es the burial-transit	Med	resulting in death) Last									
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o.	D 0 0	ysic	Part II. Other significent conditions	contributing to deat	h but not resultin	g in the und	erlying cause gi	ven in Part I.	23b. Did	tobecco use co		the cause of death?
<u>α</u>	that the ed by detac	H.	Cerebrovasco	clar &	diseas-	e			1 🗆	Yes 2□ No	3 ☐ Prob	ably 4 10 Onknown
Division of Vital Records,	Se Libe	Completed by Physiclan/							24a, Was	an autopsy	24b. We	re autopsy findings
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Re	The law cate has b	ошр							10	Yes 2 100		Yes 2□ No
ta	icien: The certificate rector, pag	BeC	25. Was case referred to medical					26. Place of Deatl			- '	1163 20110
$\geq$	<b>2</b> ω <del>1</del>	TOB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2 ER	/Outpatient	3□ DOA Oth	hor:	2,000	dence 6 🗆 Oth	ner (Specify	7)
0 0	ig Phy ter thi neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,		b. Time of Injury	28c. Inju Wo			how injury occur		,
<u>.</u>	Attending or death. ector: After by the fune	atic	2 ☐ Accident investigat	ion	,,	,,		Yes 2□No				
ž	r Atter de irecte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of	Injury - At home , etc. (Specify)	, farm, stree	t, factory, office		28f. Location ( City or To	Street and Numb wn, State)	ber or Rura	Route Number,
Ω	oital curs al nurs al nurs al liled i		00 0 17									
	To the Hospital or Attending Phy within 24 hours after death.  To the Funerel Director: After thi completely filled in by the funeral.	edical	29a. Certifier 1 ☐ Certifying I (Check only one) 2 ☐ Medical Ex	Physiclen: To the beasi aminer: On the basi and manner	s of examination	age, death o and/or inve	eccurred at the ti stigation, in my o	me, date and place, opinion, death occurr	and due to the ed at the time,	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
	o the	₩e	29b. Signature at d tit and le tifia		Juliou.		29c. Licens	se number		29d. Date signe	d (Month, I	Day, Year)
	P \$ P 0		In holde	Sin	an		Da	053337		Dovenh	ner a	6 2017
	פות		30. Name end address of person wh	completed cause	of death (Item 23	a) (Type, Pi	rint) .					
	Dr.		Dorothy Seay	mD 3	1800 Lo	Hsfo	rd Vist	053337 ra Road	H;M	chelluil	lev	Nd
	Sta		31. Date filed (Month Day, Year)	2012 32. Red	Istrar's Signature	1 1						
	Registr	ar	NUV Z	2014	neur 1	a. A	are			<u>-</u>		

DHMH 16 Rev 6/95

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State		artment of Health tificate of Death			40085
			Registrar  1. Decedent's Name (First, Middle, Last)		inoato o. Douti.	2, Date of De		3. Time of Death
	Physicia Medic		Barbara Ann Borras			Novemb	er 22, 2012	1:45 a M
	Examin	er	4a. Facility Name (if not institution, give street and number)  15401 Maple Dr.		4b. City, Town, or Location Accokeek	of Death	4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birl Min. (Month, Da	th g. Birt	thplace (State or Foreign
L	Director		577–46–9731 1 ☐ M 2 🛂 F 77	Yrs.	Months Days Hours			aryland
	and show	or	10a. State 10b. County	10c. City, Town or Loc				10d. Inside City Limits
	Maryl 28a-f otifie	Director	Maryland Prince George	Accoke				1 ☐ Yes 2 💢 No
	ith the	ralD	10e. Street and Number  15401 Maple Dr.		10f. Zip Code 20607		10g. Citizen of What Co	ountry?
	eath w	Funeral	11. Marital Status 12. Was Decedent E	ver in U.S. 13. V	Vas Decedent of Hispanic Or	igin? (Specify Yes or No-	14. Race - Ame	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.	No	Yes, specify Cuban, Mexical  Yes 2 No Specify		Black, White Specify: Wh	e, etc. nite
15-0	"2 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation ind of work done during mos	at of working	16b. Kind of Business/	Industry
212	vithin / iene. ir than the M	Con	Elementary/Secondary (0-12) College (1-4 or 5	+)	Secretary		U.S. Gover	nment.
nd	filed v al Hyg d othe	Be c	17. Father's Name (First, Middle, Last)			ner's Name (First, Middle,		
yla	uld be I Ment narke natic (	입	Melvin Sparrow			Mary		
Ma	1 and 2 should be of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  Joseph Borras Husba		g Address (Street and Number Maple Dr., P			o Code)
nore,	Page 1 and ment of Hea ant: If item ury or othe		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place) Nov	7. 23 <sup>pate</sup> 2012	20c. Location - City or Alexandria,	
Baltimore,	permit. Page 1: Department of I Important: If it any injury or of		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens		tan Funeral S Name and Address of Facili 1111ams Funer 270 Hawthorne	JOT A TOO		
	EB = 0 0	7.0	23a. Part 1. Enter the disease, or complications that caused					Approximate
J	Physician/		shock, or heart fallure. List only one cause on each line  Immediate Cause (Final disease or condition	entin				Interval Between Onset and Death
	Medical Examiner		resulting in death)	consequence of):				
		ner		consequence of):				
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c					
0	nath certificate be executed attending physician and for use as the burial-transit	dical E	resulting in death) Last Due to (or as a	consequence of):				
8760	ificate ig phy: as the	Medi	IF FEMALE:					
Box 68	death cert the attendir hed for use	Physician/Me	23b Was decedent pregnant 23c. If yes, outcome of	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day <b>Y</b> ear
P.O.	hat the ed by detac		Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause given in Part	1. 23e. Did to	obacco use contribute to	the cause of death?
	quires t	ed by				1 🗆	Yes 2 No 3 □ P	robably 4 🗌 Unknown
Records,	e law rec s has bee ige 2 sho	Completed				24a. Was autoj perfo	psy prior to death?	topsy findings available completion of cause of
	an: Th tifficate tor, pa	o.	25. Was case referred to medical		26. Place of Dea	ath (Check only one)	2 <b>Ø</b> No 1 □ Yes	s 2 No
Ž	hysici his cer al direc	To B		nt 2 ER/Outpatien		ursing Home 5 AResid	dence 6 Other (Spec	ify)
n of	ding P. h. After t funera	cate:	27. Manner of Death  1 Autural 5 Pending 2 Accident Investigation	y 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐	_	now injury occurred	
Division of Vital	I or Atten after deal Director: d in by the	Certificate:	3 Suicide 6 Could not be	ry - At home, farm, stre (Specify)			Street and Number or Ru vn, State)	ral Route Number,
L	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Examiner: To the best of only one) 3 Certifying Murse Practitioner: To the	amination and/or invest	igation, in my opinion, death o	occurred at the time, date a	and place, and due to the	cause(s) and manner stated.
	To th Within	<	29b. Signature and title of certifier  William (Minutes)		2gc License number		20d Date signed (Mont)	Day Vear
	80-10		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, P	D3521 Wingolm Ra	al Fut	WASHIMATIN.	MAY/mh
į	Sta Registra		31. Date filed (Month, Day, Year) 7 2012 32. Registra	r's Signatury	all			/
			1/ /					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26<sup>Day</sup> 2012 3:45p M Nov. Joseph Burton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Elkton Union Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth Funeral 1 XM 2 🗆 F Days Months Hours Min 2/14/1943 **Director** 215-42-6166 69 DE Usual Residence of Decedent of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City. Town or Location 10d Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Elkton MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 USA 726 Jackson Hall School 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Yes 2 No Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Lumber Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Unknown Unknown any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lewis / Friend 315 Beech Grove Ct. Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/30/2012 Newark Cemetery Newark, DE 22. Name and Address of Facility R.T. Foard & Jones, In 122 W. Main St. Newark 21 Signature of Funeral Service License Inc. 23a. Part it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Liver Cirrolisis Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ysician and le burial-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 phy: the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown ed by the a detached f 9 Unknown To the Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 X No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural 124 hours after death. Funeral Director: After objected filled in by the fur Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHWAWAZ KHAW MD 19 HERMAN HWY, SUITEA, CHESAPEAKE CITY, MD 21915. AUGUSTINE

State Registrar 32. Registrar's Signature

12-08863 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Otis Norman Benjamin State of Maryland / Department of Health and Mental Hygiene 2012 40087 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day November 21, 2012 **Medical Examiner** 1724 hrs Otis Norman Benjamin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 529 Baron Road North East Cecil 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Director 220-24-7631 CountryMaryland 1XXM 85 09/24/1927 2\_\_\_F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XXNo 28a-f show Maryland Cecil North East marked other thao "oatural", or items 23a or 28a-f sho c eveot, the Medical Examioer must be ootified at ooce. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 529 Baron Road <u>United States</u> 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Armed Forces? 1XX Yes If Yes, Give Year US Army 3 X Widowed 4 Divorced 1 Yes 2xx No specify: White ò 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. College (1-4 or 5+) MD 21215-0036 11 Assembly Line Manufacturing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Otis B. Benjamin <u>Agnes Ba</u>iliff 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is P.O. Box 126, Lewisville, Pennsylvania Amy Benjamin Marx / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State November partment o Mayerdale Crematory 24, 2012 Donation 5 Other Specify Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home, P.A. 21. Signature of Funeral Service License 127 South Main Street, North East, Maryland21901 23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last has been signed by the attending physician and 2 should be detached for use as the burial - transi Division of Vital Records, P.O. Box 68760, tall or Attending Physiciae: The law requires that the death certificate be executed Physician/Medical x AMENDED 24a-b, per me, g935 1-8-13 sm UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? page Yes 2 N 1 X Yes To the Hospital or Attending Physiciao: within 24 hours after death.

To the Fuocral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self FOUND: Natural 1 Yes 2 V No Pendina Nov 21, 2012 1720 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 529 Baron Road, North East, MD (Specify) Single Family Home Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10 + IVA

Patricia Aronica-Pollak MD. State Registra

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

November 22, 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	ase Type or Pri							=		Legible		
	-	For State	State of M	arylan					and IV	ientai Hyg	giene	201	2 1.0	000
		Registrar  Decedent's Name (First, Middle	l acti		Ce	rtificat	e or L	<i>Jeath</i>		2. Date of Dea	Reg. No.	<u> </u>	_ 4 U	<u>U 0 0</u>
Physicia: Medic	al	Dovis			7	020	m	OVR	10-11	Month DVCW	Nolv	23,20	2 19.3	
Examin	er	4a. Facility Name (if not institution)	, give street and number)	In < 0	Hal	4b. City	Town, or	Location	of Death	116	4c.	County of De	ath	
Funeral		5. Social Security Number	6. Sex 7. Ac	e (In yrs. Va	ast birthday)			If Under	24 Hrs.	8. Date of Birt	h	9. B	irthplace (State o	or Foreign
Director		215 78 8456	1 □ M 2 💆 F	5	4 Yrs.	Months	Days	Hours	Min.	(Month, Da) 08/14/	195	8	NC	
od at.	F	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation							10d. Inside C	itv Limits
arylar e-fst fied a	Director	MD			Balti									2 🗆 No
or 28	直	10e. Street and Number				10f. Zi	p Code			Т	10g. Citi	izen of What (	Country?	
with s 23a ust b	Funeral	706 N.Curley	Street			2	1205	5			U	SA		
death item:		11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S	3. 13.	Was Dece	dent of Hi	ispanic On	igin? (Spe	cify Yes or No- Rican, etc.)	T	14. Race - Am Black, Wh		
after	è	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🛱 Divorced	If Yes, Give	No		1 🗆 Yes						Specify: B1		
ature	Completed	15. Deceder	nt's Education		16a. Dec	edent's Usu	al Occup	ation				nd of Busines		
n 72 l	Ę	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1-4 or s	5+)	(Give	kind of wo DO NOT us	rk done d e retired)	during mos	st of worki	ng		Trade	Bindi	ng
withi ygiene her th	ပ္ခဲြ				Bool	K Bir	der					Co.		
e filec ad ott	To Be	17. Father's Name (First, Middle, I	,							(First, Middle,	Maiden S	Sumame)		
d Mer mark netic	-	Herbert Baze			T					Bell	0"	T 011		_
permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Importent: if item 27 is marked other then "natural", or items 23a or 28e-f show eny injury or other treumetic event, the Medical Evariner must be notified at once.		19a. Informant's Name/Relations Doris R.Bazer		ter						Route Number				
f Hee		20a. Method of Disposition		20b. F	Place of Disp	osition (Na	me of			Date	20c. Lo	cation - City	or Town, State	
Pege nent o		1 Bunal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			emetery, cre			:e)	12/1	/2012	Win	dsor,	NC	
permit. Departrimporte		21. Signature of Juneral Service I	Licenses / h	1									Home 2	7983
89888		Jameeu	ycowia	cy o	11	2.0.	Box	447	Win	dsor,	Nor	th Ca	rolina	
Physician/		23a. Part 1 / Enter the disease or shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each lin			iter the mo	de of dyin	g, such as	cardiac o	r respiratory arr	est,		Approxima Interval Bet Onset and	ween
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be executed sician and burial-transit		that initiated events resulting in death) Last	C. Due to (or as	a consequ	uence of):									
te be nysicia he bu	dical		d											
intificating ph	Physician/Medic	IF FEMALE:	On House sutcess	of progna									1	
ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 Feta	al death 3	☐ Ectopic		Э				23d. Date of o Month		Year
he de y the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 🗆 Unknown											
that the ned be deta	by P	Part II. Other significant condition	ons contributing to death h	but not res	sufting in the	underlying	cause giv	ven in Part	t I.	23e. Did to	bacco u	se contribute	to the cause of o	leath?
quires en sig ould b	ted		·							1 🗆 '	Yes 2	□ No 3 □	Probably 4 🖸	Unknown
aw re las be s 2 sh	Completed									24a. Was autop	Sy	prior to	autopsy findings completion of c	
cate h											rmed? 2 No	death?	es 2 🗆 No	
iclen certifi rector	Be	25. Was case referred to medical examiner?  1	Hospital:				Oth	ace of Dea	· ·					-
Phys r this eral di	و: 2	27. Manner of Death	28a. Date of inju	ury	ER/Outpati 28b. Time		OA 28c. Injur	4 ⊔ N		me 5 Resid			ecify)	
nding ath. r: Afte	icat	1 Natural 5 ☐ Pendir 2 ☐ Accident Investi	ng (Month, Da igation	y, Year)	injury	м	work	? Yes 2			1			
r Atte	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ				treet, facto	y, office			28f. Location (S City or Tow			Rural Route Numi	ber,
oital o urs ef rrel Di														
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.	Medical	(Check 2 - Medical I	g <b>Physician:</b> To the best of <b>Examiner:</b> On the basis of e g <b>Nurse Practitioner:</b> To th	examinatio	n and/or inve	estigation, in	my opinio	on, death o	occurred at	the time, date a	nd place	and due to the	e cause(s) and ma	anner stated.
To the vithin compl	2	29b. Signature and title of certifie		ie best of t	ny knowiece		c. License		ate and pra	ice, and due to t		e signed (Mor		
		> Chil.	ster		M.V.	).   1	745	3-0	SO	Ir	404	unhe	123 a	012
6.10		30. Name and address of person		death (Item	1 23a) (Type,		- )	da-		1 1 1	2	11		- 10
Dar		31. Date filed (Month, Day, Year)	ahiw 32. Registr	rar's Siana	turat	180	0 0	Mea	n5 C	>Weet.	Dat	hmove	MD 3	1281
Stat Registra	e ir	31. Date filed (Month, Day, Year)	6 2012 32 registr	u s oigra	B. A	ark	/							

DHMH 17 Rev 06-2011

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mary		partment of l Partificate of l		nd Men		- 0.0	1 1 17	1-0000
		-	Registrar     Decedent's Name (First, Middle, La	st)	CE	eruncate or t	Jeatri	2	Date of Deat	leg. No. /		3. Time of Death
	Physicia Medic		George Roland Ba	nnister, Jr.	•				Month DV •		2012	14:25 м
	Examin	er	4a. Facility Name (if not institution, given Hospice Of St.			4b. City, Town, o		Death	4c. County of Death St. Mary s			's
	Funeral Director		5. Social Security Number 6. S 213 02 8294		yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hours	Min. (	Date of Birth Month, Day, 04/19	Year)	9. Birth Cour	place (State or Foreign http://
	and show	o	Usual Residence of Decedent  10a. State  10b. County	10	c. City, Town or L	ocation						10d. Inside City Limits
	Maryla 28a-f	irect	MD St. Mai	ry's	Clemen	ts						1 ☒ Yes 2 ☐ No
	n with the	Funeral Director	10e. Street and Number 24513 Horseshoe I	Road		10f. Zip Code 2062	4		1	10g. Citizen of USA	What Cou	ntry?
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Madeal Exertinar must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☎ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, P	i? (Specify ` Puerto Ricai	Yes or No- n, etc.)	Bla	ce - Americk, White,	
215-(	in 72 hou e. nan "nat Moder	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)		(Giv	edent's Usual Occup e kind of work done DO NOT use retired)	during most of	f working	- 1	16b. Kind of Business/Industry		
7	dygien ther th	BeC	12 17. Father's Name (First, Middle, Last)		Ch	ef	40.44.11.11	N (F)		Priva		
/lanc	d be file Vental I arked o atic eve	힏	George R. Bannis	ter, Sr.			Agnes			Maiden Surnam	ne)	
, Mar.	nd 2 shoul ealth and 8 m 27 Is ma		19a. Informant's Name/Relationship ( Rena S.Bannister)			ling Address (Street 3 Horsesh				•		Code)
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery, cri Charles	position (Name of ematory or other place Mem. Cem.	12,	Date /01/2	012	20c. Location Leonar	dtown	n, MD
Bai	permit. Page Department Important: I any Injury or		21. Signature of Funeral Service Licer	fututa		22. Name and Addre 8576 Bret						
1 1	Physician/		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the one cause on each noe.		nter the mode of dyir	g, such as car	rdiac or res	piratory arre	est,		Approximate Interval Between Onset and Death
	Medical Examiner	L		Due to (or as a co	nsequence of):							
	rted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	if any, leading to immediate  Due to (or as a consequence of):  Cause (Disease or injury								
09	death certificate be executed re attending physician and ed for use as the burial-transit	edical Ex	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):							
_	tificate ng phy as th	Med	IF FEMALE:									
Division of Vital Records, P.O. Box 68	Physiclan: The law requires that the death certific this certificate has been signed by the attending trail director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ctopic pregnand Other (specify)	су		<del></del>		ate of delivers	ery Day Year
ls, P.O	The law requires that the ate has been signed by ti page 2 should be detach	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause gi	ven in Part I.		23e. Did tob			he cause of death?
4ecorc	he law req te has bee vage 2 shor	Completed						_	24a. Was ar autops perforr	sy med <sub>2</sub>		psy findings available ompletion of cause of
<u></u>	lan: T ertifica ctor, p		25. Was case referred to medical examiner?	S = 32% D2		26. P	ace of Death (	(Check only		2 BLNO	TLI TES	2   110
$\equiv$	Physic this ce al dire	유	1 ☐ Yes 2 No		2 ER/Outpati	· · · · · · · · · · · · · · · · · · ·	4 L Nursi	ing Home	5 🗆 Reside	ence 6 Oth	er (Specif	HOSPICE
on o	ending Feath. or: After the funer	Certificate:	27. Manner of De th  Natural 5 Pending  Accident Investigatic  Suicide 6 Could not		ar) 28b. Time injury	worl		- 1	Describe ho	w injury occur	red	
DIVIS	tal or Att s after d al Direct ed in by		4 Homicide determined			treet, factory, office			Location (Str City or Town		er or Rura	l Route Number,
	To the Hospital or Attending Physician: which 24 hours after death: To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	(Check 2 Medical Exam	vsician: To the best of my liner: On the basis of examines Practitioner: To the best	ination and/or inve	stigation, in my opini	on, death occu	irred at the t	time, date and	d place, and du	ie to the ca	use(s) and manner stated.
•	With Con		29b. Signature and title of certifier	man-		29c. Licens	e number 055	751	2	9d. Date signe	1	
U	80-3		30. Name and address of person who	•		1		dtown	, MD 2	20650	1.	
	Stat Registra		31. Date filed (Month, Day, Year)  NOV 2 6 20	32 Registrar's 9	Signature	teles						
					4 /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Boward 13:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 123 Randolph Ave. Washington Hagerstown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Davs Hours (Month, Day, Year) Director 213-40-4266 1 🗆 M 2 🗓 F Yrs 72 May 10, 1940 Maryland ed other than "natural", or items 23a or 28a-f show event, the Meyical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 123 Randolph Ave. 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. à 1 ☐ Never Married 2 X Married 1 Yes 2 X No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o pe Nellie Hymes Arlie Ralph Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s Department of Health mportant: If item 27 Wayne C. Boward/Husband 123 Randolph Ave., Hagerstown, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 11/27/2012 20a. Method of Disposition injury or 1 Burial 2 Dremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD nions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a, Part 1. Enter the disease, or comid Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ Livia carre disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami ohysician and the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 ate has been signed by the attending p page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No. 3 Ectopic pregnancy Month 5 Other (specify) Day Year 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. Division of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2-0 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P within 2 only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Pag D0038968 Brelliter and address of person who Hoderstown, Pendleton 100 31. Date filed (Month, Day 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department			m m 1 m	100	0 1	
				rtificate of Death	Reg	1. No 2012	400	91	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of De	eath	
	Medic		Alice Wanda Barker		November	17, 2012	11:17	$\mathbf{A}^{M}$	
	Examin	er	4a. Facility Name (if not institution, give street and number) 2120 Johns Hopkins Rd.	4b. City, Town, or Location of Death Gambrills		4c. County of Death	- 1		
	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	Anne Arundel				
	Funeral Director		410-24-0037   1   M 2   F   90   Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) 9. Birthp	lace (State or F ry)	oreign	
	A	h .	Usual Residence of Decedent		Oct. 5,	1922 Tenne	essee		
	yland f sho ed at	io	10a. State 10b. County 10c. City, Town or Loc			1	0d. Inside City I		
	Mar 28a- otifie	Director	MD Anne Arundel Gambrills				1 \( \text{Yes 2} \)	X No	
	th the 3a or t be r		10e. Street and Number	10f. Zip Code		g. Citizen of What Coun	try?		
	ms 2 mus	Funeral	2120 Johns Hopkins Rd.  11. Marital Status 12. Was Decedent Ever in U.S. 13. V	21054		SA			
(0	er dez or ite niner	by Fu	Armed Forces?	Nas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - America Black, White, e	,		
9	rs afterral", Exar	ed k	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🖾 No Specify:		Specify: White	2		
5-0	hou "natu dical	Completed	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Give I	dent's Usual Occupation kind of work done during most of work	16	ib. Kind of Business/Inc	lustry		
7	hin 7%	om	Elementary/Secondary (0-12) College (1-4 or 5+) life. Do	O NOT use retired)					
2	d with	Be C	5+ Couns 17. Father's Name (First, Middle, Last)			tate Mental	L Hospi	tal	
anc	be file ental h ked o c eve	To E	Robert Pickens Millard		e (First, Middle, Maid Irene Gre	,			
Σ	ould Me marl			ng Address (Street and Number or Rura	_		- d-)		
Š	d 2 shalth an 27 is 27 is rtrau		Too. Wall	Johns Hopkins Rd					
re,	1 and of Hea item		20a. Method of Disposition 20b. Place of Dispo	sition (Name of		c. Location - City or To			
Ĕ	Page nent ant: If ury or		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	matory or other place) Memorial Gds 11/2	0/2012 D	avidsonvi11	le, MD		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	21. Signature of Fun and Service Linensee 22	. Name and Address of Facility Be	all Funer	al Home			
ш	205 20			512 NW Crain Hwy.		MD 20715			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between		
ď	Medical		Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a conjuguence of):	My disease			Onset and Dea	ath	
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6	15 11	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c						
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/89	rtifica ling p	Me	IF FEMALE:						
Rox	ath ce attenc for us	cian	23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year	ır.	
ň	ne deg / the g	Physician/Me	1  Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)			,	.	
J.	that the red by deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of deat	:h?	
Ś	uld be				1 🗆 Yes	2 No 3 Prob	ably 4 Uni	known	
Ö	as bec	blet			24a. Was an	24b. Were autop			
Records,	The la ate ha page	Completed			autopsy performed 1 \(\sum \) Yes 2	d? death?	pletion of caus	se 01	
VItal	cian: ertific ector,		25. Was case referred to medical examiner?	26. Place of Death (Check			711		
<u> </u>	Physic this c	၉	1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien		me_5 KResidence	e 6 Other (Specify)			
10 0	ding F h. After funer	Certificate:	27. Manner of Death  1. Natural 5 □ Pending  28a. Date of injury (Month, Day, Year)  28b. Time of injury	work?	28d. Describe how in	njury occurred			
200	Atten deat ctor: yy the	Ĕ	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined determined	M 1 Yes 2 No	28f Location (Street	t and Number or Rural F	Pouto Number		
UIVISION	al or / s after i Dire		4 Homicide determined building, etc. (Specify)	- 1, 135.5. J, 5.1155	City or Town, St		route Number,		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investi	ccurred at the time, date and place, ar	nd due to the cause(	s) and manner as state	d.,		
	the H hin 24 the F nplet		only one) 3 Certifying Nurse Practitioner: To the best of my knowledge,	death occurred at the time, date and pla	the time, date and pi ice, and due to the ca	lace, and due to the caus ause(s) and manner as st	se(s) and manne ated.	r stated.	
	So So		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, D	ay, Year)		
			20 Name and old draw of supposition completed across of death (them 200) The D	072375		11,19,12			
	iow		30. Name and address of person who completed cause of death (Item 23a) (Type, Pi Kather, re Anderson 116 Defense H	Ighway, Suite Al	oo knno	polis, Mo	2140	1	
	Stat	-	21 Date filed (Month Day Voor)					$\overline{}$	
	Registra	r	NOV 2 0 2012	are					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23 PM Physician/ Month Day Year Brown ames Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore UMMC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye NOV 9 1 Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 084-32-8896 Director 1 XM 2 - F Nov 1940 Virginia 72 Yrs. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 Dogwood Rd. 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black Specify: 3X Widowed 4 □ Divorced Year or Dates. Vietnam 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11th College (1-4 or 5+) Master Printer ARINC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Julian Brown Mable Hobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Dogwood Rd. Annapolis, Md. 21403 Denise Brown (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite eny injury or ot 1 Burial 2 XCremation 3 Removal from State 11-26-12 4 Donation 5 Other (Specify) Baltimore, Md. Metro Crematory . Signature of Funeral Service Licenses WanName Reduces of Lacil Cons Mortuary, P.A. Larry 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Khapdomusivsi Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physicien: The within 24 hours after death.
To the Funeral Director: After this certificate it completely filled in by the funeral director, pag 1 ☐ Yes 2 Ø No Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 🗆 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02299 111 12

State

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Registrar

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Baltimore,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jabolick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9, Physician/ William Bentley 8:22 P M 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 670 Americana Drive, #43 Anne Arundel Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 260-72-2716 65 Director 1 X M 2 D F Georgia 2/7/1947 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f NC 1 X Yes 2 No Wake Raleigh 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe I ms 23a must be Funeral 5508 Pine Drive 27606 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Software Engineer Information Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ၉ Jack Bentley Audrey Morris and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : Kathi Bentley - Wife 5508 Pine Drive, Raleigh, NC 27606 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Page 1 Important: If it any injury or o once. 1 XBurial 2 Cremation 3 Removal from State 12/1/2012 4 Donation 5 Other (Specify) Raleigh Mem. Park Raleigh, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Huteriose disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Medical Certificate: To Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate or Attending Physician: after death.

Director, After this certific Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) xaminer? 1XYes 2 \(\subseteq\) No 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practitioner: To the best of m

Registrar

State

31. Date filed (Month.

695 America

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #19A, per FH, QACHD, MS, 11/27/1 Certificate of Death Registral 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 22, 2012 12:40 BORIS CONSTANT BELL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S CENTREVILLE 137 SONATA WAY 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Director 176-14-2822 1 **X** M 2 □ F 91 APR. 23, 1921 **PENNSYLVANIA** ye 1 and 2 should be filed within 72 hours efter death with the Maryland tof Health end Mental Hygiene. If item 27 is marked other then "netural", or Items 23e or 28a-f show or other treumetic event, Ite Medical Examination ust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CENTREVILLE MD QUEEN ANNE'S 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21617 USA 137 SONATA WAY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces' 1 Never Married 2 Married Š X Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) COLLEGE ADMINISTRATOR **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ ALFRED HONORATO BELPULITI ELETTRA FERRARI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 406 CHESTERFIELD AVENUE, CENTREVILLE, MD 21617 Date 28, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION permit. Page 1
Department of
Importent: If it
eny injury or o NOV. 1 Burial 2 Cremation 3 Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final congestive Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and I-transit Exami The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician ( Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year isigned by the at P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by vascular disease Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate • Hospital or Attending Physician: 1 24 hours after death. • Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify) Hospital: 1 Tes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After the in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of denti 29d. Date signed (Month, Day, Year) D47311 11/26/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 101 Chester, mo 21619 Suzanne Niemela 1630 Main St 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar park.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:25 P.M 2012 Kevin Douglas Bussie November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Burtonsville Sanctuary at Holy Cross If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/13/1964 9. Birthplace (State or Foreign Country)
Wash., D.C. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 577-84-6531 1 [XM 2 □ F 48 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Bladensburg Md. Prince George's 10g, Citizen of What Country? 10e. Street and Number Funeral 20710 U.S.A. 5215 Newton Street # 302 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 X Never Married 2 ☐ Married \$ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Washington Gas 12th Senior Gas Mechanic traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba file and Mental | is marked o မ Robert Bussie Isabell Scruggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Paga 1 end 2 sh Depertment of Haalth ar Important: if item 27 is any injury or other trau once. 1606 H St., S.E., Washington, D.C. Stanley T. McMichael/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 😡 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/23/12 Landover, Maryland Harmony Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licenses CC0316 any snall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of) Examiner Severe Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funerei Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Intractable Nausea, Vomiting that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Stage IV Gastric Carcinoma Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dunknown Completed Bacteremia 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 S Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marmer as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 20,2012 D0064100 MING BSM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, M.D. 1500 Forest Glen Road, Silver Spring, Maryland

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (*Month, Day,* Year) NOV 2 6 2012

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 2:15 $P^M$ November Clarence Baxter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Genesis Layhill Center If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 248–42–1609 **Funeral** Age (In yrs. last birthday) Days Min (Month, Day, Year) Director 1 💢 M 2 🗆 F 83 pril 14, 1929 South Carolina Usual Residence of Decedent 28a-f show 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director District of Columbia Washington 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 United States 943 Jefferson Street, NE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 1 Never Married 2X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Divorced 4 Divorced American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Contract Specialist Government years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Luther Baxter Rosa Mack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarice Baxter Lea - Daughter 8110 Gorman Ave. #332 Laurel, MD 20707 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemt. November 24 2012 Brentwood, MD M00560 Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of death certificate be executed physician and the burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? death? 2 No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 XNursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending

Box 68760 P.O. Records, After this certificate completely filled in by the funeral director, Division of Vital Hospital or Attending Funeral Director:

within 2

Accident

Suicide

4 Homicide

only one)

29b. Signature and title of certific

65M

State Registrar

Medical

DHMH 17 Rev 06-2011

ORIGINAL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number

November 16, 2012

D0064208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saadia Husain, M.D. 3227 Bel Pre Road Silver Spring, MD 20737

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) NOV 2 6 2012 . Registrar's Signa

Investigation

determined

6 Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ,201<sup>Year</sup> Physician/ 6:02 A Barksdale November Stonewall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 2711 Kirtland Avenue District Heights If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours Director 224-34-9755 1 X M 2 □ F 84 Usual Residence of Decedent 10. Virginia or 28a-f show notified at show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 X Yes 2 □ No Maryland | Prince George's District Heights 10f. Zip Code 10e. Street and Numbe 10a. Citizen of What Country? r items 23a or ner must be n Funeral 20747 United States 2711 Kirtland Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status er than "natural", or ite Armed Forces?

1 Yes 2 X No If Yes, Give Black, White, etc.
African 2 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Pepco 3rd Installer Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Grasty Barksdale Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 2711 Kirtland Avenue District Heights, Md. Dora Dean Barksdale - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Java, Virginia Riceville Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licenses John T. Stewart 32 4001 Benning Road NE Washington, DC M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metostatic Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-trai Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Day Year 5 Other (specify) Month Pregnant at time of death be detached 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 1 Yes 2 No Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DCA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: or Attending 1 X Natural 5 Pending after death. Director: Al 1 Yes 2 No filled in by the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide the Hospital 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Fune

completely fi 29a. Certifier (Check 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and Atle of certifie 29c. License number 29d. Date signed (Month, Day, Year)

450

Registrar
DHMH 17 Rev 06-2011

State

7525 Greenway Center Drive Ste. T-3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

\$2. Registrar's Signature

Mehrdad Mostaasn,

D24061

November 26, 2012

Greenbelt, Md.

20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Catherine Brown 2:01 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** salisbur WICOMICO Hospice 1 Year If Under 24 If Unde 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) 220-01-8612 **Director** 1 M 2 X F 92 10/21/1920 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31568 Old Ocean City Road 21804 USA Maryland 21215-0036 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Manufacturing Quality Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Kirwan Brewington Gertrude Ennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31568 Old Ocean City Rd., Salisbury, MD 21804 James W. Brown Jr/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State 11/26/2012 Salisbury Crematory Salisbury, MD Donation 5 C Other (Specify) Side natur Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1. Enter the disease. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and physician and s the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? signed by the atte Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of 20 No 1 Yes 1 Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Hospie ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at ature Certificate: 28d. Describe how injury occurred injury Natural work? 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Analysing Numer Practitude of the cast of any confeder, sealth occurred at the time, date and place, and the cause(s) and manner secretary. 29b. Signature and fitle of 29c. License number 29d. Date signed (Month, Day, Year) 163FF address of person who completed cause of death (Item 23a) (Type, Print). SALISBURY MD 21804. VOHLA 910 EASTERN SHORE

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 21, 20°1°2 2:15 Рм Louise Ruth Bilbrough Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline 25380 Smith Landing Rd. Denton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth Min. Maryland 1 □ M 2 Ϊ Months Days Hours August 13, 1 **Director** 213-22-6666 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a State 10h County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Caroline Denton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21629 USA 25321 Smith Landing Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 XWidowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker/farming Self empl. produce retailer 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Frances Shaffer Loman Luther Ott, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Dale Bilbrough, Sr./son 25321 Smith Landing Rd. Denton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) 11/25/2012 Greensboro, Maryland Greensboro Cemetery Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, Denton, MD South 2nd Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) erebrovaso Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to lor as a consecuence of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day Year should be detached 1 ☐ Yes ∠ ∈ 9 ☐ Unknown Unknown signed by contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1- Natural injury 5 Pendina Accident Investigation 1 Tes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. are and title of certifier 29b, Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, 32. Redistrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clarence Edward Boston 2012 lovem ber Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospita Easton Talbet Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 220-03-8397 Director 1 M 2 □ F 94 April 7, 1918 Maryland Usual Residence of Decede 2 should be filed within 72 hours after death with the Meryland th and Mental Hygiene.

27 is marked other then "naturel", or items 23a or 28e-f show traumetic event, the Model Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Denton Maryland Caroline 1X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21629 USA 803 Riverview Gardens 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1943

If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced Specify: Black Year or Dates to 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Boston, Clarence Elementary/Secondary (0-12) College (1-4 or 5+) 8 Lumber Company Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Boston Edith Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 end 2 sh Department of Heelth ar Important: If item 27 is eny Injury or other trau once. Dante Wilson/P.R. 510 High Street Denton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore Veterans Cem. 11/26/2012 Hurlock, Maryland 21. Signature of Funeral Service Lights Moore Funeral Home, P.A. 22. Name and Address of Facility eld 12 South 2nd Street Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ardiac Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician end I for use es the burial-transit To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the Innerial director, page 2 should be deteched for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical e1 Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number D48324 Alchrostion Villance 11/18/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTON Alchrystian Willanz MHE 2195. WASHINGTON 50 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 20 201 Registrar

Bar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOV Howard Jackson Bradshaw, Jr. 2012 2:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5524 Galestown Newhart Mill Rd Dorchester Seaford Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 221-54-0843 Director 1 X M 2 - F 47 Yrs. Maryland Jan. 24, 1965 or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Dorchester MD Seaford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19973 5524 Galestown Newhart Mill Rd United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+ Welder/Fabricator Welding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard J. Bradshaw, Sr. Mary Ann Nossick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Bradshaw/Spouse 4966 Skeet Club Rd., Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Nov. 2012 Galestown, Maryland 4 Donation 5 Other (Specify) Galestown Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility P.A. 216 N. Main St., Federalsburg, MD 21632 Muhal 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Metastatic Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month J Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 2 No 1 🗆 Yes 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 2 Z No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? Natural 28d. Describe how injury occurred 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my spiriter death occurred. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 11-20-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) 32. Registrar's Sign NOV 2 7 2012 Registrar DHMH 17 Rev 06-2011

NS 14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Betty Louise Bullock November 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Easton labot Memorial Hospital at Easton If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 218-20-7320 1 □ M 2 🗓 F Maryland 86 March 29, 1926 Usual Residence of Decedent or 28e-f shov 2 should be filed within 72 hours effer death with the Maryland the end Mentel Hyglene.
27 is marked other then "neturel", or items 23e or 28e-f shortreumetic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21629 USA 8921 Fisher Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced Bullock, Bethy 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Chief Deputy Clerk Caroline Co. Circuit Court Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beatrice Elizabeth Erskine Ernest Asche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth item 27 8842 New Bridge Road 21629 Rebecca Manship/friend Denton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of importent: If it eny injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Denton Cemetery 11/19/2012 Denton, Maryland 21. Signature of Funeral Service Liespee 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South 2nd Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final Physician Faulure disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the ettending physician and ched for use as the burial-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be a within 24 hours efter deeth.

To the Funerei Director. After this certificate has been signed by the ettending physicial completely filled in by the funeral director, page 2 should he detanhed the contractor. Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No <u>م</u>| Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Number Practitionar To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 29b. Signature an D0053815 Mame and address of person who completed cause of death (Item 23a) (Type, Print)

KORAH M. PULIMOD 2195 WAS 2195 WASHINGTON ST EASTON MD 2/601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 9 201 Registrar

DHMH 17 Rev 06-2011

12-09143 Larry Coates Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health, and Mental Hygiene

Larry Coates		Reg. No. 2012 4010;							
Physician/ Medical Examiner	1/ 1. Decedent's Name (First, Middle,Last)  2. Date of Do  Month  Larry Emanuel Coates, Jr.  Decemb	peath Day Year Der 1, 2012 3. Time of Death 1639 hrs							
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death							
Funeral	Holy Cross Hospital  Silver Spring  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8, Date of 1	Montgomery  Birth/MWDD/YYYY) 9. Birthplace (State or Foreign							
Director	213-02-4342 X M 2 F 30-31 Yrs. Months Days Hours Min. 10/20	0/1981 Foreign 6/1981 Country) MD							
yna	Usual Residence of Decedent  10a. State	10d. Inside City Limits							
te Maryland or 28a-f show any fied at once. Jirector	MD Prince George's Forestville	1 XYes 2 No							
the Maryland or 28a-f sh itified at once	10e. Street and Number 1644 Tulip Avenue 20747	10g. Citizen of What Country? USA							
er death with t	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Normal New Married 2 Married Proces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.							
fter dea	1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify:	Specify. Black							
nours aft transfer	O TOLDATES.	16b. Kind of Business/Industry							
5-0036 ed within 72 hour lygiene. other than "natu ine Medical Exau Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  Laborer	Private							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatite event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director									
212 hould by ad Ment is mark tile evel	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route N								
and 2 si cealth ar tem 27	Bernice Zanders/Mother   1644 Tulip Avenue Fores	tville, MD. 20747							
TOFE	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Heritage Cemetery 12/7/12	Waldorf,MD							
Baltimore, permit. Pages 1 at Department of Hee Important: If ite	21. So ure of Funeral Service Ligensee 22. Name and Address of Facility Briscoe-	-Tonic Funeral Home							
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a								
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a Asphyxia during restraint	Between Onset and Death							
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.								
niner									
60, ste be executed stystician and e burial - transit Medical Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
iox 68760, eath certificate be executed a sttending physician and for use as the burial - transit /sician/Medical Ex	X UNPENDED								
i8760, ruffcate be ning physici as the buri	FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 Live birth   2 Fetal death   3 Ectopic pregnancy	23d. Date of delivery  Month Day Year							
b. Box 687 the death certification by the attending pother for use as the Physician/I	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown								
P.O. Es that the d		tobacco use contribute to the cause of death?							
ords, P w requires t s been sign should be c		res 2 No 3 Probably 4 ✓ Unknown as an 24b. Were autopsy findings available							
Records, The law requires ficate has been sig page 2 should be Completed	aut	opsy prior to completion of cause of formed? death?							
ital Reciena: The leina: The leice certificate leector, page	25. Was case referred to medical 26.Place of Death (Check only one)	s 2 No 1 Yes 2 No							
F Vit	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5	Residence 6 Other:							
on on or cuding ath.  or: Afte function:	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  28d. Describ into c into c during	e how injury occurred subject went ardiorespiratory arrest restraint							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical E	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific) Inside Vehicle Could not be determined (Specific) Inside Vehicle	(Street and Number or Rural Route Number, City							
Hospita 24 hours Funcral tely fille		Spring,MD.							
To the Howithin 24 Page 124 Pa	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and manner stated.	te and place, and due to the cause(s)							
<b>△</b>	29b. Signature and title of certifier  29c. License number  O.C.M.E.	29d. Date signed (Month, Day, Year)  December 2, 2012							
02.0	30. Name and address of person who completed cause of death (Item 23a)								
State	Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 2 31, Date filed (Montrace, Part) 0010   32 Registrar's Signature	21223							
Registrar	TIFE I LOUIC   Market of Cl. Colored								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0:06 PM Richard Hillman Cornell Vovember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Plata -IVISTA La 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Director 214-28-4185 193d Maryland Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1√2 Yes 2 □ No Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 50 Circle Ave. 20640 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. ь Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 1 ☐ Yes 2 V No Specify: Specify: White "natural" 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Plumber Government Be laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be 1 nent of Health and Ments Hillman Cornell Ella Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra Mary Ann Cornell Wife 50 Circle Ave., Indian Head, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) NOV 20c. Location - City or Town, State . Date 2012 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gardens Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sen Williamsdruneral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the shock, or heart fai Interval Between Onset and Death ure. List only one cause on each line. Immediate Cause (Final Septic snock Physician/ disease or condition resulting in death) Medical **Examiner** Infected Sun Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Yea Other (specify) 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No eral Director: After this certificate filled in by the funeral director, pag 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No ၉ 1 Tes 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a

State

Registrar

29a. Certifier

only one)

3

person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

agata tre 10646

29d, Date signed (Month, Day, Year)

20,2012

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 27 **Physician** 2ďT2 05:00PMM Eva I. Campbell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil Elkton Laurelwood Care Center 8. Date of Birth (Month, Day, Year) Jan. 30, 1922 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours North Carolina 1 ☐ M 2 😿 F 90 246-28-2949 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must ha maritimal and injury or other traumatic event, the Medical Examinar must ha maritimal and injury or other traumatic event, the Medical Examinar must have been existed. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1XXYes 2 □ No Director Elkton Cecil Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States Funeral 102 Decker Street Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, GiveXX Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Baugus Lon Brooks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 200 East Main Street, Elkton, Maryland 21921 Clara E. Campbell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition December 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State North East United Methodist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1, 2012 North East, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland 21901 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an nas page 2 s autopsy perform<u>ed</u> this certificate 1□ Yes 2□No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Hospital or Attending Injury \_1 ☐ Natural 5 ☐ Pending investigation 1 ∏Yes 2 ∏No ne Funeral Cirector. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) n by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D0026183 November 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Madhu Sachdev, MD 322 East Cecil Avenue, North East, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State O Carper Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death November 23 2012 Physician/ 12:02AM Cole Medical Carol Ann 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 219-44-4513 1 🗆 M 2 🗓 F 67 NOV.4,1945 Virginia Usual Residence of Deceden ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1X Yes 2 No Maryland Frederick Jefferson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4416 Jefferson Pike 21755 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic ever Lincks Hilda Thurston Darr permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Cole / Spouse 4416 Jefferson Pike/ Jefferson, Maryland 21755 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State ŏ Stauffer Crematory Nov.25,2012 Injury ( Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lious 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/Frederick, MD 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Probable Physician/ disease or condition resulting in death) Myocardia Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No ☐ Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D 60 35261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Frederick MD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Maryland	d / Department of I	Health and N	/lental Hyg	jiene	
			<ul><li>State Registrar</li></ul>		Certificate of	Death	R	teg. No. 2 1 1	1.0107
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ALC: NO.	Medic Examin		4a. Facility Name (if not institution, give		4b City Town o	or Location of Death	1 11	4c. County of Dear	71
	Examin	er	10800 Lee	Acres Dr	Bra	k.		Prince	George
	Funeral		5. Social Security Number 6. So	7 1-		If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
ė.	Director			□ M 2 LF U7	Yrs.	Hours Min.			untry)
	nd now st	_	Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Location		1- 20	- 1965 Ma	10d. Inside City Limits
	arylar a-f sh fied	Director	1 1 P.	0					1 ☐ Yes 2 ☐ No
	or 28 noti		10e. Street and Number	beone 13	randywine 10f. Zip Code			10g. Citizen of What Co	
	23a	Funeral	10800 Lee	Acres De	20	613		USA	
	leath Items er mi	Fun	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I		ecify Yes or No-	14. Race - Ame	
36	", or	δ	1 Never Married 2 🛚 Married	1 ☐ Yes 2 🔀 No If Yes, Give	1 Yes 2 X No		riidari, cto.j	Black, Whit	1
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed	3 Widowed 4 Divorced	Year or Dates.	16a. Decedent's Usual Occup			9	
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yla	uld be fil Mental narked o	욘	Kudolph		binson	Margar	et		Estep
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	and 2 s Health tem 27		Edward Curtis 20a. Method Disposition		10900 Lee	Acres yr	Date	20c. Location - City or	1
nou			1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	metery, crematory or other pla	ce)	10-12	Class	Marked
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shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
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mark.	Examiner			Due to (or of a conseque	Silice Oly.			1	
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200	phys	ledic		d					
687	eath certifica attending ph d for use as t	ln/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan-	cy death 3 D Ectopic pregnan			23d. Date of de	livery
Вох	is that the death igned by the atter be detached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🔀 No	4 Pregnant at time of de		icy		Month	Day Year
P.O.	t the lby the stacke	Phy	g ∐ Unknown  Part II. Other significant conditions or		Iting in the underlying source of	iven in Part I	00. 51.4.4	pacco use contribute to	. N
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ecc	nysician: The law inscentificate has to director, page 2 s	dmo					autops perforr	med? prior to death?	completion of cause of
E B	an: Th tificat tor, po	BeC	25. Was case referred to medical		26. P	Place of Death (Chec	l 1 ☐ Yes : k only one)	2 K Nol 1 L Yes	s 2 No
Ĭ.	Physicia this cer	10 B	examiner? 1 ☐ Yes 2. ☒ No	Hospital: 1  Inpatient 2  E	ER/Outpatient 3 DOA Oth	ner: 4  Nursing Ho	ome 5 🗷 Reside	ence 6 Other (Spec	cify)
of	ng Pł fter th uneral		27. Manner of Death  1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of 28c. Injury wor	k?	28d. Describe ho	w injury occurred	
ion	tendi death tor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b			Yes 2 □ No			
Division of Vital Records,	l or Attending after death. Director: After d in by the fune		4 Homicide determined	building, etc. (Specify)	ne, farm, street, factory, office		City or Town	reet and Number or Ru n, State)	rral Houte Number,
<b>₽</b>	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	edical		sician: To the best of my knowle iner: On the basis of examination					
	o the hithin 2-	Me		se Practitioner: To the best of my		the time, date and plant	ace, and due to the		as stated.
	F S F O		Maron 7	Nouskew Cs	WP RO	5729	3	11/23	
	4-1-4		30. Name and address of person who o	completed cause of death (Item 2	23a) (Type, Print)		, .		
	Da		Maren Mayne 31. Date filed (Month, Day, Year)	80\ McC 110 32. Jegistrar's Signatu	ormick Dr #	180 Lar	go MD	20774	
	Stat Registra		NOV 2 6 2	112 June 1	8. park		•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04:08 AM 2012 Donua Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Pince MI inton Georg Social Security Number 7. Age In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace State or Foreign **Funeral** Months Days (Month, Day, Year) Hours 517-54-4876 Director 1 🗆 M 2 💢 F 76 Usual Residence of Decedent 16-Washington 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at Director Waldorf Maryland
10e. Street and Number 1 Tyes 2 No harles 10f. Zip Code 10g. Citizen of What Country? Funeral 6313 U54 eerwood 20603 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: should be filed within 72 hours aft, and Mental Hygiene. Is marked other than "natural", Blac 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 Is eny Injury or other trau once. Waldorf 3 31 20603 ACCO erwood 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State MI 4 Donation 5 Other (Specify) h Id ont Signature of Foneral Service Licensee 20608 22. Name and Address of Facility MASCO 23a. Part 1. Enter the disease, or complications that caused the bleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PERPORATION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NECROS CTAL Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 ☐ Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 A No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 A No or Attending Physician: The 25. Was case referred to medical examiner? Division of Vital Be ( 26. Place of Death (Check only one) Hospital: Other: ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) V006 20135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONARA SURRATT CLINTONM ENNETH State 26 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	FOR	Department of Health and N Certificate of Death		/ 11 1 /	40109	
_			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death	g. No.	3. Time of Death	
	Physicia Medic			4RL	Month	18 Zol	2 /035 M	
The second	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea		
, sele	Funeral		2706 Afton St.  5. Social Security Number   6. Sex   7. Age (In yrs. last birth.	Temple Hills  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince G	thplace (State or Foreign	
	Director		570_20_9023	Months Days Hours Min.	(Month, Day, Yo		nington, DC	
	ld 10w	١	Usual Residence of Decedent         90           10a. State         10b. County         10c. City, Town	or Location	November 1	, 1922 Wasi	10d. Inside City Limits	
	arylar la-f sl	ecto	Maryland Prince Georges Temple H				1 ☐ Yes 2 🗓 No	
	the M	Ē	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?	
	n with	Funeral Director	2706 Afton St.	20748		J.S.A		
9	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ No If Yes, Give	<ul> <li>13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto</li> <li>1 Yes 2XX No Specify:</li> </ul>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W		
8	ours a atural' cal Ex	Completed	3 ⚠ Widowed 4 □ Divorced Year or Dates.	Decedent's Usual Occupation	11	6b. Kind of Business		
215	n 72 h e. an "na Media	du	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)			gence Support	
7	d withi ygiene her th it, the	Be Cc	12 Fe	deral Police Officer			enter	
and	be filed antal H ced ot c ever	To B	17. Father's Name ( <i>First, Middle, Last</i> )  John Milton Carl, Sr.	Anna Ruth	e (First, Middle, Ma Clark	uden Surname)		
ary	1 and 2 should be file of Health and Mental H item 27 is marked o other traumatic eve			. Mailing Address (Street and Number or Rur		City or Town, State, Z	ip Code)	
Ž	and 2 sl Health a em 27 is ther tra		(daughter)	3248 Guilford Dr. Waldorf	MD 20602			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 si Department of Health si Important: If item 27 i any injury or other tra once.		1 X Burial 2 Cremation 3 Removal from State cemeter	Disposition (Name of y, crematory or other place)		0c. Location - City o	r Town, State	
E E	oit. Page artment o ortant: If injury or		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  WOISSS	22. Name and Address of Facility Lee		Clinton, MD		
Ba	Depz Impo	-	Jessica Comoroza	6633 Old Alexandria Fe			735	
-	Physician Medical	4 7	23a. Parl 1. Enter the disease, or complications that caused the death. Do not shack, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a	ROSTATE	or respiratory arrest	t,	Approximate Interval Between	
es esta	Examiner		Due to (or as a consequence of	11).				
15	_ +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nij,				
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0	ute be executed hysician and the burial-transit	dical E	d d					
68760	ificate ng phy as the	Medi	IF FEMALE:					
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of d	elivery Day Year	
О.	t the do	Phys	9 ☐ Unknown 9 ☐ Unknown		1 00 51111			
S, P.	requires that the dec been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Fact.	1 \( \text{Yes}	acco use contribute to the cause of death?  S Probably 4 Unknown		
Division of Vital Records,	aw requas beer 2 shou	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
Ř	sician: The law is certificate has the				perform		es 2 🗆 No	
ital	Physician: T this certifica aral director, p	) Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Impatient 2 FR/Out	26. Place of Death (Chec		C C Other (Cos		
of <	g Physer this	e: To	27. Manner of Death 28a. Date of injury 28b. T	Time of 28c. Injury at	28d. Describe how	nce 6  Other (Spe v injury occurred	сну)	
on	ttending F death. stor: After t	fical	1 Natural 5 Pending (Wonth, Day, Year) 1 2 Accident Investigation 3 Suicide 6 Could not be	njury work?  M 1 ☐ Yes 2 ☐ No				
VISI	of or Attend after death Director: A d in by the f	Certificate:	4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,	
	Hospital 24 hours a Funeral I		29a. Certifier Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place,	and due to the caus	se(s) and manner as	stated.	
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/o only one) 3 ☐ Certifying Nurse Practitioner: To the best of my known	or investigation, in my opinion, death occurred a wledge, death occurred at the time, date and p	at the time, date and lace, and due to the	place, and due to the cause(s) and manner	e cause(s) and manner stated. as stated.	
	To the within 2		29b. Signature and title of certified	29c. License number	8 29	od. Date signed (Mon	who 192012	
	J.		30. Name and address of person who completed (a) se of death (Item 23a) (	Type, Print)		1.1.	- MA -	
	pori		MICHAEL J. LOTENTAMO	YHY DEFENSE	HWYT	INNAPOL	15 MD2140)	
	Sta Registr		31. Date filed (Month, Day Year) 6 2012 32. Fegistrar's Signature	pare				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended # $\mathbf{1}$ - State Registrar 26, tchd, 11/16/12, r1s Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 9:47 AM Elinor in. Cooper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tent Cee Chestertown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min. Maryland Director 08-11-192 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho **Funeral Director** 1 🗌 Yes 2 🔀 No nestertow 10g, Citizen of What Country? USA 1620 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Black 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) eacher's Be 17. Father's Name (First, Middle, Last) ၉ Bankins Beatrice James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr., Pasadena, Ca. 9//
Date 20c. Location - City or Town, State Merrett Cooper-daughte 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗌 Burial 2 🛣 Cremation 3 🔲 Removal from State Direct Crematory LLC 11-21-12 Dover, Delaware
22. Name and Addless of Facility Bennie Smith Fungral Home 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen EGSTON, Maryland 21601 426 Dover Street, 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hours Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Year 1 Yes 2 LL 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1) Orthostation Hypotension 2 No 3 Probably 4 Unknown (D) Hyperten 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed death? 2 PNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 D No Hospital: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Li Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \( \text{Yes} \quad 2 \( \text{No} \) injury 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director,

State

Medical

29a. Certifier

11/1llling, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

415 Washington Ave.,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

D21313

Chestertown MD 21620

29d. Date signed (Month, Day, Year) 11/14/12

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\mathbf{A}^{\mathsf{M}}$ LUCILE PIERCE CORKRAN NOVEMBER 9, 8:15 2012 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) TALBOT WILLIAM HILL GARDENS **EASTON** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day. 9. Birthplace (State or Foreign Country) ZONE Days 9/10/1923 038-12-9541 89 PANAMA CANAL Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No TALBOT EASTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21601 7428 KAREN AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2**X**No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MARY SELLERS CHARLES LESTER PIERCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7428 KAREN AVENUE, EASTON, MD 21601 SHARON CORKRAN, DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SPRING HILL CEMETERY 11/14/2012 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERCERO 200 SOUTH HARRISON STREET, EASTON, MD 21601 MHOL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bleed disease or condition resulting in death) Due to (or as a consequence of): Advance Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery Month Day Year use contribute to the cause of death? ☑Nio 3☐ Probably 4☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

10a State

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If frem 27 is marked other them: any injury or other traummit

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, It e Madical Examinations to a volim dist

Examine attending physician and for use as the burial-transi Physician/Medical been signed by the should be detached by Completed certificate has birector, page 2 st Be Certification: To After this within 24 hours after death

To the Funeral Director:
completely filled in by the

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2.★No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic preg 5 ☐ Other (speci		
Part II. Other significant conditions	contributing to death but not resulting in	the underlying caus	e given in Part I.	23e. Did tobacco L
				24a. Was an autopsy performed? 1 □ Yes 2 ☑ No
25. Was case referred to medical			26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA	Other: 4   Nursing Ho	me 5 Residence
7 Manner of Dooth	29a Date of Injury 29h	ime of 28c	Injury at	28d Describe how injur

						1 □Yes 2 ZNO	1 ∐Yes 2 ∐No
25. Was case referre	ed to medical				26. Place of De	eath (Check only one)	
examiner?	lo	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 🗆 DOA	Other: 4 \sum Nursing	Home 5 Residence 6	SOther (Specify) Asy + L
27. Manner of Death  1 Natural  2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Ye	28b. Time of Injury	280 M	c. Injury at Work? 1 □Yes 2 □No	28d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		At home, farm, street	, factory, c	office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,

(Check only one)	2 Medical Exam

ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29b. Signature and title of certifier R077623 29d. Date signed (Month, Day, Year)

nwood Dr Easten MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) NOV 1 3 2012 32. Registrar's Signature

RS 10

Medica!

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George L. Cahen  $P^{M}$ 2:40 November 2012 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death 4b. City, Town, **Examiner** Annapolis The Arbor at Baywoods Anne Arundel 8. Date of Birth (Month, Day, Year) Nov. 1, 1921 If Under 1 Year If Under 24 Hrs. Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 227-12-8995 91 Director 1**X**MM 2 □ F Virginia Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10c. City, Town or Location notified at Funeral Director Maryland Anne Arundel Annapolis 1 Yes 2XXNo 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be reading injury or other traumatic event, the Medical Examiner must be reading injury or other traumatic event, the Medical Examiner must be reading injury or other traumatic event. 705 Howards Loop 21401 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces?

1XXYes 2 \( \subseteq \) No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Specify: 3 Widowed 4 Divorced WW II Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Aerodynamacist U.S. Navy Be 7. Father's Name *(First, Middle, Last)* **Emile Cahen** 18. Mother's Name (First, Middle, Maiden Surname) ပ Blanche Nagelsman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Cahen/son 705 Howards Loop Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemetery Unk. Arlington, Virginia neral Service License 22. Name and Address of Facility John M. Taylor Funeral Home va 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery be detached the signed by

Completed by page 2 should filled in by the funeral director, Be Certificate: To

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To the Hospital

in the past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)
Part II. Other significant condition	ns contributing to death but not resulting i	n the underlying cause given in Part I.

oths?		1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown						Mo	nth	Day	Year
nt conditions	cont	ributing to death but not res	sulting in the underlyin	g cau	se given in Part I.		23e. Did tobacco				of death?
							24a. Was an autopsy performed?	, E	orior to d death?		ngs available of cause of
medical			nly one)								
0	Но	spital: 1	ER/Outpatient 3	DOA	Other: 4 Nursing I	Home	5 Residence	6 Othe	er (Speci	ty) Ass	15510 liv
Pending		28d. Injury at (Month, Day, Year) 28b. Irime of injury at work? 1  Yes 2  No					d. Describe how inju	iry occurre	ed .		
☐ Could no determine		28e. Place of Injury - At he building, etc. (Specify	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Medical Exa	mine	an: To the best of my know r: On the basis of examinatio Practitioner: To the best of I	n and/or investigation,	in my	opinion, death occurred	at the	e time, date and plac	e, and due	e to the c	ause(s) an	d manner stated.

29d. Date signed (Month, Day, Year)

To the Funeral Director: After completely filled in by the funer completely filled in by the funeral Machine Contification
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Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

a 31. Date filed (Month, Day, Year)

5 Pending

25. Was case referred to medical

examiner?
1 Yes

27. Manner of Death

1. Natural

2 Accident

4 Homicide

only one)

29b. Signature and title of certifier

29a. Certifier

ava Kol

2200

NOV 2 0 2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 6:45p <sup>M</sup> November Joyce Ann Carter 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Heartland of Hyattsville Hyattsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 579-56-0421 1 🗆 M 2 🔀 F 04-05-1943 69 Washington, D.C Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3021 24th Street N.E. 20018 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Assistant Manager Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudolph Austin Clementine Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) San Juan, PR Floyd Carter/Son 63 Calle San Miguel 00911 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place 11-28-12 Brentwood, MD 4 Donation 5 Other (Specify) Ft.Lincoln Crematory 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each 23a, Part 1 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final Carcinomo fasta tic vanan disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

Physician/ Medical **Examiner** 

Physician/

Medical

**Funeral Director** 

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Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036

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the Funeral Director; After this certificate has k filled in by the funeral

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Division of Vital Records,

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1 Yes 2 No 9 Unknown	9 Unknown	death 5 🗆 Other (	specify)	World Bay real			
art II. Other significant conditions art II. Other significant conditions	TA.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown					
Carebon O	ascular ac	ecidout	1 Stroke	24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2 PNo 1 Yes 2 No			
5. Was case referred to medical		26. Place of Death (Check only one)					
examiner?	Hospital: 1 Inpatient 2	Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4 Nursing Home 5  Residence 6 Other (Specify)					
7. Manner of Death  1 Natural 5 Pending 2 Accident Investigat		28b. Time of injury M		28d. Describe how injury occurred			
3 Suicide 6 Could no 4 Homicide determine	280 Place of Injury At he	ome, farm, street, facto	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
9a. Certifier 1 Certifying P	hysician: To the best of my know	ledge, death occurred	at the time, date and place, a	and due to the cause(s) and manner as stated.			

Defice a Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

PLAZIE. ROCKULLE AM

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOV. 2012 Brian Henri Chollet 4:00 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Easton Talbot Talbot Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 1 X M 2 □ F 213-70-9770 56 3-23-1956 Maryland 28a-f show ?7 is marked other than "neturel", or items 23a or 28a-f sho treumatic evant, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Talbot Neavitt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6324 Neavitt Manor Rd. 21652 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married <u>۾</u> Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working el Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Boat Operator Environmental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file end Mentel F is marked of မ Raymond Chollet 1 and 2 should be Mere Haalth end Mere Item 27 is mark Mary Lee Byrne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Chollet/wife P.O. Box 435, Neavitt, MD 21652 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Pege 1.
Dapartment of I
Important: If its
eny injury or ot 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 11/19/12 MidShoreCremationCtr. 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 22. Name and Address of Facility Mid Shore Cremation Center 21. Signature of Funeral Service Licensee Atlaule , CFSP P.O. Box 1464, Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final Priysician/ LUNG CANCER METS disease or condition resulting in death) 42S Medical Due to (or as a consequence of): Examiner MOUTH CANCER Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a por sequence of physician end s the burlal-transit or Attending Physicien: The law requires that the deeth cartificeta ba executad that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 ettending pl IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, this cartificate has bean signal director, page 2 should! 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 1 Yes 2 No rs after death. ei Director: After this cartificati led in by the funeral director, pr 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide To the Hospital or Atte within 24 hours after der To tha Funerel Director completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) D39887 11-19-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

DR. DAVID H.

NOV 2 U 201

31. Date filed (Month, Day, Year)

32. Registrar's Signature

SMITH, 8221 TEAL DRIVE, EASTON, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 605 Physician/ ERNEST CHARLES DARDIS Medical 4b City Town or Location of Death Examiner <sup>4a</sup> Eacility Name (if not institution, give street and number)
THE GARDENS OF WILLIAM HILL MANOR 4c. TALLBOTeath If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 105-28-1990 Director 1 **X**M 2 □ F 02/04/1937 BROOKLYN, NY 75 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10d. Inside City Limits aţ Director Examiner must be notified 1 X Yes 2 No MD TALBOT EASTON ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 28924 JASPER LANE 21601 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 A Yes 2 □ No If Yes, Give Black, White, etc. ě þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", Completed 3 Divorced 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4 or 5+) 5+ Elementary/Secondary (0-12) the NAVAL OFFICER UNITED STATES NAVY ye 1 and 2 should be filed with t of Health and Mental Hygier If item 27 is marked other? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ERNEST VICTOR DARDIS AGNES CRAWLEY 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANA CATHERINE DARDIS/WIFE 28924 JASPER LANE EASTON, MD 21601 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. CHESAPEARED CREMATEION 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/16/2012 STEVENSVILLE, MD 21. Signal ₽ENALOWSgorHELFEINBEIN & NEWNAM FUNERAL HOME, P.A. Service L 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Interval Between Immediate Cause (Final Onset and Death Physician/ Tailure disease or condition Medical resulting in death) **Examiner** AlZheimer Sequentially list conditions. Examine than, leading to intraclate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed and -trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 phy IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Vear Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s has autopsy performed? Yes 2 No 1 ☐ Yes 2 KNo Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Asst Living 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral n 24 hours after deau... he Funeral Director. After th maletely filled in by the funera 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2, To the F complet only one) 3 Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

45 Cynwood

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Redistrar's Signature

R077623

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WASHINGTON CENTER BURNIE (In yrs. last birthday) 83 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min 217-26-0505 **Director** 1 🗆 M 2 💢 F July 09,1929 Maryland 28a-f show 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified Anne Arundel Severna Park MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral 23a USA 21146 426 Arundel Beach Road items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or i þ 1 Never Married 2 X Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. 21215-0036 1 Yes 2 No Specify: White Specify Completed 3 Widowed 4 Divorced er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher alth and Mental Hygien 27 is marked other the r traumatic event, the Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillian Herr George Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 Arundel Beach Road Severna Park, MD 21146 Ralph Darley / Husband Department of Health Important: If item 2; any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November Metro Crematory, INC Baltimore, MD 2012 Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, Part 1 Inter the disease or complications that caused the death. Do not enter the mode shock, or heart diure, List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami the burial-tra resulting in death) Last physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Pregnant at time of death be detached the 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 3 Probably 4 Unknown Completed 1 Yes 24a. Was an Were autopsy findings available has page 2 autopsy prior to completion of cause of 1 ☐ Yes 2 ☐ No 1 Yes the Hospital or Attending Physician: filled in by the funeral director. 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 Yes 2 🗌 No s after death ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

State Registrar of person who completed cause of death (Item 23a) (Type, Print)

BWWC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HENRY MARTIN DERMODY, JR. NOVEMBER 24 2012 5:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 117 QUAIL RUN DRIVE CENTREVILLE QUEEN ANNE'S If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) **Director** 013-30-0581 Usual Residence of Deced 1 X M 2 🗆 F 73 FEB.13,1939 NORTH CAROLINA or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 😿 No QUEEN ANNE'S CENTREVILLE 10e. Street and Numbe ō iral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 117 QUAIL RUN DRIVE 21617 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced It Yes, Give 1958-1993 Completed Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ COLONEL U.S. ARMY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည HENRY M. DERMODY, SR. EVELYN K. REMIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i KATHLEEN T. DERMODY/ WIFE 117 QUAIL RUN DRIVE, CENTREVILLE, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State NOV. 27. permit. Page 1
Department of I
Important: If it
any injury or or 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION
CENTER STEVENSVILLE, MD 2012 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disea Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Fulmonore Medical resulting in death) Examiner Sequentially list conditions cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last 00 Due to (or as a consequence of) use as the burialphysician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed certificate Yes 2 X No 1 Yes 2 No the Hospital or Attending Physician: funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Aftert Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury To the Hospital or Attendi within 24 hours after death To the Funeral Director: A the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certification 29c. License numbe 29d. Date signed (Month, Day, Year) 0036242 4+W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 37M + chells Chance Rd #180. Edgen Les MA homos lanisn NOV 2 0 2012 Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Davis 14 2012 3:25 Farl Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/19/1926 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min. Hours Director 1 X M 2 □ F 86 W.Va. 236-36-1858 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other treumatic event, the Medical Examiner must be notified at 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pa. Adams Littlestown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 17340 377 Lumber Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, was beceden Ever in 0.3.

Armed Forces?

1 ★★es 2 □ No
If Yes, Give
Year or Dates 1944-46 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Radial Drill Operator Defense Ind. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Iva Mae Harper Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred H. Davis (wife) 377 Lumber St. Littlestown, Pa 17340 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Carmel 11/17/201 Littlestown, Pa. Sign ture of Funeral Service Licenses 22. Name and Address of Facility LITTLESTOWN PA 17540 34 MAPLE AVE own ITTLES 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit **Hospital or Attending Physician**: The law requires that the death certificate be executed 24 hours after death. and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 cate has been sig Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence OW 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 After this funeral ( Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending neral Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD. 12 30 Name and address o 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1<sup>Mont</sup>6-201<sup>2</sup> 6:55 A CLYDE DUNCAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PG TEMPLE HILLS 4705 BIRCHTREE LANE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours 439-40-2117 80 1 X M 2 □ F Director 10-23-1932 LA Usual Residence of Decedent or 28a-f show 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location Director Examiner must be notified 1 X Yes 2 □ No TEMPLE HILLS PG10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20748 US 4705 BIRCHTREE LANE items death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify. 3 XWidowed 4 □ Divorced Specify: BLACK Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ELECTRICAL ENGINEER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ ROBERT DUNCAN OLIVIA ELLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 st partment of Health a portant: If item 27 is y injury or other tra OLIVIA D. TUTMAN/DAUGHTER 4705 BIRCHTREE LANE, TEMPLE HILLS, MD 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit, Page 1 a
Department of P
Important: If ite
any injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛣 Other (Specify) INURNMENT ARLINGTON CEMETERY 12-19-2012 ARLINGTON, VA 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. of Funeral Service Li <u>5538 MARLBORO PIKE, FORESTVILLE, MD 20747</u> 23a. Pag 1. Enter the disease, or complications that caused shock, of heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown g . Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 X Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: 4 Nursing Home 5 TResidence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending injury 1 Natural
2 Accident
3 Suicide 1 🔲 Yes 2 No within 24 hours after death

To the Funeral Director: /
completely filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitionar: To the best of my knowledge de 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Kouchchou, D63748 Jecete jo Jin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOCELYNE KOUATCHOU, 4041 POWDER MILL RD, BELTSVILLE, MD 20705 M.D. 31. Date filed (Month) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Esperanza Claro Dialino Month 11-21-2012 6:25 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3802 Meadowhill Rd Springdale Prince George's Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 11-21-1919 Director 219-88-6179 1 M 2 3 F 93 Phillipines "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Prince George' Springdale 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20774 3802 Meadowhill Rd Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Asian Completed 3 X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker PVT. 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fortunato Claro Victoria Babelonia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manuel C. Dialino Son 4318 Medallion Dr. Silver Spring, MD20904 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cemetery crematory or other place)
Milaor Cemetery 12-1-12 Phillipines 1 Burial 2 Cremation 3 Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) Remove21. Signature of Funeral Service License 22. Name and Address of Facility Pridgen Funeral Country Mawara 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Heart Failure Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending phase as the IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Year the 9 Unknown signed by t P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has page performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner' Hospita 1 ☐ Yes 2 🔀 No Other: မ 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending ours after death.

neral Director: Aff 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours at To the Funeral D completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0051122 11/23/2012 of death (Item 200, 30. Name and address of person who co (Item 23a) (Type, Print) 65M 1160 20017 NE #008 Wash., DC Jaunitez v2 6 2012

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month

amend Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov 26, 2012 Ronald C. Ellis 7:41 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's S218ec38N6746 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months (Month, Day, Year) 218 48 6746 Hours Director 1 XM 2 □ F 71 Yrs Jan 13, 1941 Washington, DC ul Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 No Yes 2 □ No Morningside 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4310 Maple Road 20746 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Iron Worker Local 5 Welder. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file h and Mental F 7 is marked of Leo Ellis Dorothy Reher 19a. In Duste Now Perform III Types Pri (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 si it of Health a If item 27 i Karen Ellis (wife) 4310 Maple Road, Morningside, MD 20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If in any injury or conce. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lee Crematory Nov 29, 2012 Clinton, MD Signature of Fungral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria mo139 Ferry Road, Clinton, MD 20735 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 2 12avs shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ savamous cell carcinoma. disease or condition resulting in death) Lung Medical Examiner obstructive 4 caus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine mass-merastate disease monl attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): mellitus type II 724ears Physician/Medical DMBETES Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Abdominal Aneurysm -24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 🖹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying rights and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number D 0 4 2 0 4 9 29d. Date signed (Month, Day, Year) November 26, 2012 Upper Manlboro. MD. 20772 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alain G. Champaloux mn-31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Worth Year 12 3-024M Mary Evans 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BW Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) Mar 30 1 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 216-32-0894 Director 1 ☐ M 2 💢 F 82 Yrs 1930 Maryland Usual Residence of Decedent or than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1986 Dominoe Rd. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. φ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Completed **Black** Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health end Mental Hygiene. Importent: If item 27 is marked other than 'eny injury or other treumatic event, the Ma Anne Arundel Elementary/Secondary (0-12) 10th College (1-4 or 5+) 0 Nurse General Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sherman Dorsey Sadie Creek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamie L. Evans(Son) 1986 Dominoe Rd. Annapolis, Md. 21401 Baltimore, 20a. Method of Disposition 20b. Plate of Disposition ( ) specific of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 11-23-12 Annapolis, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Winname Receive of SciliSons Mortuary, 1922 Forest Dr. Annapolis, 21401 Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Du lo for as a consequence cardio Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P. Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Suppatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
injury
28c. 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Cectifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated le of gertifie 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DWUSU 31. Date filed (Month, Day, Year) NOV 2 0 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nonth Nov. Year DADAH 8:53 PM MAND HASHI 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ockville Monta Red Clover Drive omery 9. Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 126-36-7465 **Director** 1 XM 2 🗆 F 79 932 Iraa Usual Residence of Decedent show 10a. State notified at 10c. City, Town or Location 10d Inside City Limits Director 28a-f 1 Yes 2 No 10e. Street and Number Tonta 10f. Zip Code ms 23a or must be n 9 10g. Citizen of What Country? Funeral Iraq Drive 20853 NVPC items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Was Decedon.
Armed Forces?

1 Yes 2 No Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner s, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health care Elementary/Secondary (0-12) College (1-4 or 5+) Physcian Services Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eldadah Abdullah Amna Hussain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Potomac, 9905 Eldado Chape 20854 Lay Son oad 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ↑ Surial 2 ☐ Cremation 3 ☐ Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Park Mem. permit. MUSLIM FUNERAL SERVICE 22. Name and Address of Facility ADEN 21. Signature of Funeral Service Licer Mo#1070 22191 Easy Woodbridg VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner bue to (or as a consequence of, Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death Year ed by the a detached 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy After this certificate has filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work?
1 Yes 2 No Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ÉCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 111 6277 2<sub>JM</sub> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20854 Totomai MD Tuckerman Ln

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month)

MARK OF PRAME

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, Examiner 4b. City, Town, or Location of Death County of Death 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months Hours (Month, Day, Year) Country Director 183-40-9815 1 ☐ M 2 🖾 F Yrs. 1949 63 14, PA ir than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 XNo PA Dauphin Harrisburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1061 Pond Ridge Drive 17111 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1X Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other treumatic event, the Mar College (1-4 or 5+) 5+ Elementary/Secondary (0-12) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Engle Betty J. Harman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spring Valley Rd Apt C2 Harrisburg, Michelle Zimmerman/Sister 4101 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. ROCK Date , 20c. Location - City or Town, State Dec. 2012 1 X Burial 2 Cremation 3 X Removal from State Mt. 4 Donation 5 Other (Specify) Lewistown, PA . Signature of Funeral Service Licen 2. Name and Address of FacilityJJ Hartenstein Mortuary, 24 Second St. New Freedom, PA 17349 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of) Due to (or Examiner esto 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine anding physician and use as the burial-transit Cause (Disease or injury that initiated events Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 40 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 200 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes 2 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) f 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

DEC 1 0 2012

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State	or Maryland / L	•	ate of De		a ivioritai		Dee Ne	201	2 40125
Physician		Registrar 1. Decedent's Name (First, Middle,Las	)					2. Date of De		\$ ·	3. Time of Death
Medical Examine		Richard Joseph	Force					Month Novemb	er 20, 2	Year 2012	0650 hrs
		4a. Facility Name (if not institution, give					Location of De	eath		. County of De	ath
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Funeral Director		5. Social Security Number 6. Se		yrs. last birt		Inder 1 Year onths Days		Min.		1	Birthplace (State or Foreign Country)
Director	-	213-10-3333	M 2 F	52	Yrs.			7/30	)/19	60	PA
à	-	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town	or Location						10d. Inside City Limits
d d	$\lfloor \rfloor$	MD Cecil		Elkt	on						1 Yes 2x No
Maryland 28a-f show any 1 at once.	읽	10e. Street and Number		EIKU		Zip Code			10g. Citiz	zen of What C	ountry?
the M	Director	36 Ajs Court				21921				USA	
with ns 23 be no		11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Dec	edent of His	panic Origin?	( Specify Yes or N	10-	14. Race - Am	nerican Indian, Black,
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after	濟.	3 Widowed 4 X Divorced	or Dates:		1 Yes					Specify: W]	
hour:	ᅙ -	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	ly highest grade comple College (1-4 or 5+)	ted) 16a. l	Decedent's Us during most of				16b. K	(ind of Busine:	ss/Industry
36 hin 72 than dien	E	12	College (1-4 of 5+)	D	inafil	++0=			D : .	~~E3T1	
ed wit ygien other	Completed	17. Father's Name (First, Middle, Last)		1 5	ipefit		18.Mother's Na	ame (First, Middle		pefit: Surname)	Ling
21215-0036 Suld be filed within 7 Mental Hygiene. marked other than e event, the Medie.	e n	William George	Force				Donn	a Keipe	er		
D 21 hould and Me is ma ntic ev	٥ [	19a. Informant's Name/Relationship (T	rpe, Print )	198	. Mailing Addr	ess (Stree	t and Number	or Rural Route N	umber, Ci	ty or Town, St	ate, Zip Code)
MC salth au alth au an 27 raum?		Donna Kammer / 20a. Method of Disposition	mother	20h Blace o	41 Gre	enha	ven D	r. Elkt			or Town, State
Ore, es la of He fiker ti		1 Burial 2 X Cremation 3	Removal from State		ory or other pla			1/24/12		Location - Gity	or rown, state
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		4 Donation 5 Other Specify:		R.T.	Foard	Fune	ral H	ome, P.	A. 1	Rising	Sun, MD
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	see		R.T.	Foa	rd Fu	neral H	lome	, P.A.	
Physician	+	23a. Part I. Enter the disease, or comp		death. Do no	1 259 t enter the mo	E M de of dying,	ain S such as cardia	t <u>Flkt</u> ac or respiratory a	rrest, sho	MD 21 ck, or heart	Approximate Interval
/Medical	1	failure. List only one cause on ea  Immediate Cause (Final disease a.	ch Jirle. Hypertensive Athe	roscleratio	: Cardiovas	cular Dis	ease				Between Onset and Death
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	<u></u>	cause. Enter Underlying Cause	Due to (or as a conseque	ence of):							
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760, cate be execut physician and he burial - tran		UNPENDED	AMENDED				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
876 lificate ng phy is the	2	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	of pregnancy 2	Fetal dea	ath 3	Ectopic pre	gnancy	230	d. Date of delivers. Month	ery Day Year
Box 687 e death certific the attending p	2	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time								
Bo he dea	Physician	1 Yes 2 No 9 Unknown  Part II. Other significant conditions	9 Unknown		To all a side of			Loo- Did	Anhanan i		to the cause of death?
P.O. E res that the d signed by the be detached	2	Diabetes mellitus	contributing to death bu	t not resulting	in the underly	/ing cause g	iven in Part I.	,	es 2	to promote	robably 4 V Unknown
ds, F	<u>g</u>	Diabetes memas									autopsy findings available
COF	Сошріете	·							opsy formed?		o completion of cause of
Re ificate		05 100				00 PI	-/ D#- /OL-		2 🗸 N	0 1	Yes 2 No
Division of Vital Records, P.O. and or Attending Physician: The law requires that the affect death.  The rect death.  Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director.	ן מֿ	25. Was case referred to medical examiner?	ospital: 1 Inpatient	2 FR/O	utpatient 3		of Death (Che	rsing Home 5	Reside	nce 6 🗸 Ot	her: Scene
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ViSi or Att fter de in by i	28   E	2 Accident Investigation 3 Suicide 6 Could not	28e Place of Injury	- At home, fa	ırm, street, fac	tory, office b	uilding, etc.			nd Number or	Rural Route Number, City
Spital of the filled	\ <b>-</b>	4 Homicide determined						or Town,	State)		23
Division of Vital Records, To the Hospital or Attending Physician: The law requi- within 24 hours after death. To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should child of certifications. To Be Completely		(circuit ciri)	an: To the best of my kn								
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Founeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Confification: To Bo Commission by Dureisian Madical Ex	<u> </u>	one) 2 Medical Examiner  29b. Signature and title of certifier	On the basis of examina and manner stated.	auon and/or if	ivestigation, in			eu at tile time, dal			
10	2	290. Signature and title of certifier	Al Cai			29c. Licens				ember 21,	Month, Day, Year)
(16)	L	lave 1				0.0.1	vi. L.		1404	ember z I,	2012
		<ol> <li>Name and address of person who carol H. Allan, MD Assi</li> </ol>	completed cause of deati stant Medical Exar	,	0 W. Baltir	nore Stre	et. Baltimo	re, MD 2122	3		
Stat	e	31. Date filed (Month Clay, Year)	32. Régistrar's S				,				
Registra		20 20	16 Deneur	1.	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 14 Physician/ Month Sr PM Yerr. Ford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 54. Marys 5+ MARYS Hospital heonard town 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min. (Month, Day, Year) 212-66-4823 **Director** 1 M 2 F 54 2-10-58 Maryhn Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director 1 Yes 2 No Lexington 10e. Street and Number 10g. Citizen of What Country? ö ms 23a or must be r 46356 USA 20653 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status "natural", or ite Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Black Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within I Hygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Custodian ulth and Mental Hygien 27 is marked other the r traumatic event, the 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. JAMES Guendo 20653 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route N ber, City or Town, State, Zip Code) 46356 dumbus rexi tore 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State MI 4 ☐ Donation 5 ☐ Other (Specify) 3-12 surrection 21. Signature uneral Service Lio 22. Name and Address of Facility 20608 TOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ocardia. disease or condition Medical resulting in death) Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 XYes 2 No 3 Probably 4 Unknown Ford Sr. Perry Lawethe Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an era unector: After this certificate has filled in by the funeral director, page  $2\,\mathrm{s}$ autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending injury s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DO021202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRAMER

State Registrar

deed 11/23/12

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B.D A-10-53

MD

Registrar's Signatur

Drive Charlotte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ NOVEMBER 10, 2012 HELEN HOPE FRENCH 3:52 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 216-38-9979 1 □ M 2 K F 70 FEB. 24, 1942 MARYLAND Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours aftar death with tha Merylend innent of Health and Mental Hygiene. Seture!", or items 23e or 28e-f show tent. If Itam 27 is marked other then "neture!", or items 23e or 28e-f show inry or other treumetic avent, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director TALBOT EASTON MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 USA 29441 MATTHEWSTOWN ROAD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SALES CLERK DEPARTMENT STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANCIS CRAWFORD SATCHELL ROWENA HELEN SPENCER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4346 SILVAN GLEN DRIVE, PRESTON, MD S. SUSAN CHANCE, SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PK: 11/15/2012 EASTON, MARYLAND 21. Signal ro of Fundal ervice 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ reas Months disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospitei or Attanding Phyelcian: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the ettending physician end compietaly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\begin{array}{c}\) Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 November 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKSHMI VAIDYANATHAN 2160 219 S. WASHINGTON ST, EASTON RS 6 MD

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

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			For State Of Ivial State Of Ivial Registrar		rtificate of Dea					
			Decedent's Name (First, Middle, Last)		timoute of Bet		Reg. No. Date of Death	10.	3. Time of Death	
	Physicia Medic		Charles Ernest Fisher, Sr	•		Λ	Wonth let a	26 2012	muella a.	
-	Examin	er	4a. Facility Name (if not institution, give street and number)  16040 Dellinger Road		4b. City, Town, or Location of Death  Williamsport  4c. County of Death  Washington					
	Funeral Director		Mucor	n yrs. last birthday) Yrs.		Under 24 Hrs. 8 lours Min. Ar	Date of Birth (Month, Day, Year)	9. Birti Cου	hplace (State or Foreign Intry) Maryland	
	nd how at	ř	Usual Residence of Decedent  10a, State 10b, County 1	Dc. City, Town or Loc	cation				10d. Inside City Limits	
	Marylar 18a-f sl	Director	Maryland Washington	Wi	illiamsport				1 ☐ Yes 2 🔀 No	
	n the Na or 2 be no		10e. Street and Number	,-	10f. Zip Code		10g. C	Citizen of What Co		
	ath witi	Funeral	16040 Dellinger Road  11. Marital Status 12. Was Decedent Ever	rin IIS 13 \	Vas Decedent of Hispan		/ Yes or No-	U 14. Race - Amer	SA	
920	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 X Married Armed Forces? 1 X Yes 2 No 1 Widowed 4 Divorced Year or Dates.	1947-	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🛣 No S		an, etc.)	Black, White		
2-0	2 hours "natur	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during		16b.	Kind of Business I		
Maryland 21215-0036	vithin 7 iene. r than	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	O NOT use retired)  Farmer	3		Agricul	ture	
nd 2	filed wall Hyg		17. Father's Name (First, Middle, Last)			. Mother's Name (F	irst, Middle, Maider			
ylaı	Ment Ment narke	은	Charles Macklefresh Fisher			Bertha I	Ette Uhle	r		
Mar	shou h and 7 is m traum	188	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and I					
	Healt Healt Hem 2		Connie L. Fisher - Wife  20a. Method of Disposition	20b. Place of Dispo-	Dellinger sition (Name of	Road Wi.		t,Maryla Location - City or		
Б	Page 1 nent of int: If i		1 Burial 2 Cremation 3 Removal from State	cemetery, cren Evergreen M	natory or other place)			ksburg, 1		
Baltimore,	permit, I Departin Importa any inju		21. Signature of Puneral Servot Consee	22	2. Name and Address of	Facility Osbo	orne Fune	ral Home	, P.A.	
			23a. Part 1. Enter the disease, or complications that caused the		25 S. Conocer the mode of dying, su			amsport,	MD 21/95 Approximate	
	Pnysician/ / Medical	2 1	regulting in death)	o vascular	r disea.	5e			Interval Between Onset and Death	
	Examiner		Due to (or as a co	- 1	1105cleration	e cartino	ascular o	lisease	5 years	
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	The second second	100				7	
	ecuter and Il-trans	Exan	Cause (Disease or iinjury that initiated events c. Due to (or as a corresulting in death) Last Due to (or as a corresulting in death) Last	onsequence of):	nce of):					
0	icate be executed I physician and s the burial-transit	<b>ledical</b>	d							
8760	tificate ng ph	Med	IF FEMALE:							
Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/N	23b Was decedent pregnant 23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		
, P.O.	ss that th igned by be detac	by Pł	Part II. Other significant conditions contributing to death but of	not resulting in the u		n Part I.			the cause of death?	
rds	require been s should	eted	Man It I want to be and	- Juli seg	1.00		1 ∐ Yes 2 24a. Was an		obably 4 Unknown opsy findings available	
Division of Vital Records,	The law cate has I		Mon - Hougigns Tymphom	a			autopsy performed?	prior to c death?	ompletion of cause of	
ital	sician certifi rector	Be (	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Innetient		Other	of Death (Check on	-	_		
of V	g Physer this neral di	te: To	27. Manner of Death 28a. Date of injury	2 ER/Outpatien 28b. Time of injury	nt 3 □ DOA 4		5 Residence  Describe how inju	6 Other (Special of the Control of t	fy)	
on	eath. or: Aft the fur	Certificate:	1   Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	sar) Injury	M 1 ☐ Yes	2 🗆 No				
Divisi	al or Att s after d al Direct ed in by		4 Homicide determined 28e. Place of Injury building, etc. (S		eet, factory, office	28f	. Location (Street a City or Town, Stat	and Number or Rura te)	al Route Number,	
	ne Hospit n 24 hour ne Funera pleted filk	Medical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my 2 **Medical Examiner: On the basis of examonly one) 3 **Certifying Nurse Practioner: To the best of my 2 **Certifying Nurse Practioner: To the best of my 2 **Certifying Nurse Practioner: To the best of my 2 **Certifying Nurse Practioner: To the best of my 2 **Certifying Physician: To the best of m	nination and/or invest	tigation, in my opinion, de	eath occurred at the	time, date and place	ce, and due to the c	ause(s) and manner stated.	
	To the within 2 To the comple		29b. Signature end title of certifier  Was A Balal MM		29c, License nun	825	29d. D	Pate signed (Month,	Day, Year) 2012	
7	1.1		30. Name and address of person who completed cause of death	7	11.	a olatorius	MD	2174	7	
	W-2 Stat	e.		OFN TVE	inve Ita	1 Urollian	1111	0114	~	
	Registra		MUY N O ZUIZ	w 18.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26, per versial of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Frank V. Franzone SR 2012 6:00 AM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 3105 Stonybrook Drive Bowie If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months Hours Director 084-03-4869 1 X M 2 🗆 F 99 June 03, 1913 New York 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h Counts must be notified at **Funeral Director** 28a-f 1X☐ Yes 2 ☐ No MD. Prince George's Bowie or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 20715 3105 Stonybrook Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or item Examiner p Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【☐ No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced al Hygiene. I other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4+ Pharmacist Pharmacy Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic even ည Rosario Franzone Rose Scordo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health au t: If item 27 is 7 or other trau Louise J. Franzone/ Wife 3105 Stonybrook Drive Bowie, Maryland 20715 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Sacred Heart Cemetery 11/21/2012 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. Bowie Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie MD, 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** ELTENS18V Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transit and attending physician I for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by 1 ☐ Yes 2 ★ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ieral Director. After this certificate has filled in by the funeral director, page 2 a autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 1 Inpatient 2 7 /Outr ationt 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: Or Certifying Nurse Prac te basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 295 Signature 29d. Date signed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ NOV. 12 Patricia Ann Fagan 5:35 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) Under 1 Year If Under 24 Hrs. onths Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 530-40-5073 64 1 □ M 2 🔀 F 8/2/1948 South Carolina 28e-f show or then "netural", or items 23e or 28e-f sho the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Pega 1 end 2 should be filed within 72 hours aftar deeth with the Maryland 10d. Inside City Limits Director Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2807 Kings Ridge Rd. Apt. 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Caregiver Assisted Living Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Charles T. Buffington, Jr Ruth E. Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 f Health a MacKabe Fagan - Son 1118 Bachmans Valley Rd. Westminster, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Importent: If Its eny Injury or of once. 11/1<sup>D</sup>3\*7201 1 🗆 Burial 2 🗷 Cremation 3 🗀 Removal from State outh Carroll Crematory Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home watin R. 1 Willis St Westminster. 21157 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): ettending physicien and I for use es the buriel-treneit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physicien: The law requires that the death certificate be axecuted Due to (or as a consequence of): Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Day To the Hospital or Attending Physicien: The law requires that the case within 24 hours effer death.

To the Funeral Director: After this certificate hes bean signed by the e completaly filled in by the funarel director, page 2 should be dateched it. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 💆 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 1 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Pother (Specify) VVOS 01 Co 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 303 Zen 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 2 NO210-87 Charles HARLES 6701 Men 31. Date filed (Month, Day, Year) NOV 1 5 2012 Registrar's Signature 32 State

Registrar

CECAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Althea Sylvia Farmer State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death 1729 hrs **Medical Examiner** Sylvia November 27. Althea Farmer 2012 4a. Fecility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 8504 Barron Street Silver Spring Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Foreign Washington, Months Days Hours Director 577-66-8345 1 M 2 X F 63 Yrs FEBRUARY 21 D.C Usual Residence of Decedent Iny 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No **Maryland** Montgomery Takoma Park permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at noce. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8504 Barron Street 20912 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married Yes 2 X No 3 Widowed **Black** If Yes, Give Yee 1 Yes 2X No specify: 4 Divorced Specify 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) University of College (1-4 or 5+) Baltimore, MD 21215-0036 12th grade Maryland Maryland Clerk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Jonathan Farmer Allena Virginia Joyner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Yvonne Edwards (Sister) 4613 - 22nd Avenue; Mount Rainier, Maryland 20712 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dec.5,2012 4 Donation 5 Other Specify: Maryland National Memorial Park Laurel, P.G. Co. Maryland 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Signatury of Funeral Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease Narcotic (Morphine) Intoxication xaminer or condition resulting in death) Due to (or as a consequence of):

and - transit attending physician or use as the burial signed by the atte After this certificate has funeral director, page 2 sl within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month Par

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

egistrer's Signature

**Enspiral or Attending Physician:** The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b					
edical	X UNPENDED		28a-f,per me,g9	34 12-14-	12 sm		
2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Unknow	23c. If yes, outcome of preg  1 Live birth  4 Pregnant at time of decenting the second	2 Fetal death 3	Ectopic pregnan	cy	23d. Date of delivery Month Day	Year
<u>a</u>	Part II. Other significant conditions	s contributing to death but not	resulting in the underlying cause	given in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
Completed					24a. Was an autopsy performe	prior to conded? death?	osy findings available apletion of cause of 2 No
Be (	25. Was case referred to medical		26.Plac	e of Death (Check or	nly one)		
0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA			sidence 6 🗸 Other: S	cene
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	ation Id 11-2/-12	fd: 5:10 pm 1	Yes 2 No	28d. Describe how unknown		
Certification:	3 Suicide 6 X Could no determin	ot be True De	nome, farm, street, factory, office sidence		28f. Location (Stre or Town, State <b>Takoma Pa</b>	et and Number or Rural e) 8504 Barro ark, MD.	Route Number, City  n St.
dical (	(Official office)	Iclan: To the best of my knowled her: On the basis of examination	•		,	,	

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

November 28, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gross, Sr. Melvin Amos Dec 2012 :00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles Genesis Health Care-LaPlata LaPlata 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Country) Director 220-40-6482 69 1 M 2 🗆 F 5/6/1943 Usual Residence of Decedent items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director LaPlata 1 Yes 2 No Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 1 Magnolia Drive 20646 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ō Yes 2 X No Maryland 21215-0036 72 hours after Specify: Black 1 Yes 2 X No Specify: If Yes, Give than "natural", 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 0 College (1-4 or 5+) Oyster Shucker Seafood permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie. Important: If item 27 is marked other any injury or other trainmant. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gross Matilda Johnson Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Park, 19a. Informant's Name/Relationship (Type, Print) 21627 Liberty St. Unit 1611 |Melvin Gross, Jr./son MD 20653 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Metro. Crem. 12/5/2012 Alexandria, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 1451 Dares Beach Rd. Prince Frederick, MD 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Provincian/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physician and the burial-transit tosture to this that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending phed for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death by the Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 🗌 No 1 Yes Division of Vital 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital Other: 1 🗌 Yes 2 **N**O nours after death.

neral Director: After this control of the funeral director. မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completely filled Medical 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number ٥ D070900 12/4/12 Resmons 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glem Burnie 1 MD 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gorman Physician/ December Medical 4a. Facility Name (if not institution, give street and number, **Examiner** Town, or Location of Death Baltimore If Under 1 Year | If Under 24 Hrs. Funeral Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 150-42-9958 Director 62 1 1XM 2 □ F July 9, 1950 New Jersey ıl Hygiene. | other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2√√X No Spotsylvania Fredericksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10312 Campbell Dr. 22408 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Analyst Homeland Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic ever ဂ္ Francis Gorman Irene Skowronski permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife: Debbie Gorman 10312 Campbell Dr. Fredericksburg, VA 22408 Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington, VA UNK National Cemetery . Signature Funeral Service Licensee 22. Name and Address of FacilityCovenant Funeral Service MO 1471 4801 Jefferson Davis HWY Fredericksburg, VA 22408 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner lasmacutama Sequentially list conditions. Examiner if any, leading to immediate ue to (or as a consequence of) Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death sate has been signed by the s page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes 2 No 1 ☐ Yes 2 ☐ No burs after death.

eral Director: After this certific, filled in by the funeral director, å 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 2, 2012 0 m on who completed cause of death (Item 23a) (Type, Print) Baltimore Mo 21287 Orleans State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 20, 2012 Year Physician/ 16:11 P M David L. Gray Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Cheverly If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Director 217 34 2456 1 【XM 2 □ F Maryland Jan 17, 1938 or 28a-f show 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🔽 No Maryland Prince George's Capital Heights 10e. Street and Number 10g. Citizen of What Country? Funeral 500 Shady Glen Drive 20743 United States death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 XXMarried ò Yes, Give XNo Maryland 21215-0036 be filed within 72 hours after 1 Yes 2 No 3 Widowed 4 Divorced **Black** Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David A. Gray Dorothy L. Alameda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Gray (Wife) it of Health : 500 Shady Glen Drive, Capital Heights, MD 20743 other Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If i any injury or o 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 11/27/2012 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio Myopathy Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Coronary Artery Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hypertension, Hyper Cholesterol attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Year Month Day Pregnant at time of death 2 No should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown ESRD-DP 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has perforn 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 X No 0 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Magner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: after death. Director: After (Month, Day, Year) injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

NOV 282012

Arnulfo B. Bonvente, MD 6904 S. Crain Hwy, Upper Marlboro, MD 20772

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year Nov. 1:05 a M Emily Mae Gibney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Manor Healthcare Ctr. Rising Sun Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🐺 Director 212-30-5275 Usual Residence of Decedent Yrs. 80 4/30/1932 MD or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 ☐ No MD Cecil Rising Sun 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country or items 23a Funeral Examiner must St P.O. Box 215 108 Pearl 21911 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) h and Mental Hygier 7 is marked other t 11 Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental file of Health and Mental ၉ Marion Thomas White Arvilla Terry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Gibney/ husband 108 Pearl St. P.O.Box 215 Rising Sun, MD21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important; If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Page 1 11/30/12 Donation 5 Other (Specify) Rising Sun, MD Brookview Cemetery 22 Name and Address of Facility 111 S. Queen ST. Rising 21. Signature of Funeral Service Licenses MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer nset and Death Immediate Cause (Final Alzheimers Physician/ rementia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) day, leading to improduce cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the as IF FFMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f Yes 2 No g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen ( Hupertension 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s performed' certificate 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 1 🔲 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After letely filled in by the funer 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 COCONIA MITTA 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:54 P Month Physician/ Rosa Hall Nov 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fort Washington Fort Washington Hospital Prince George's If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 7 F Min (Month, Day, Year) Hours 64 Virginia Director 230 68 1437 March 21 1948 Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗘 No Maryland Prince George Fort Washington 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 1603 Poling Ave 20744 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ıral", or iten I Examiner n 11. Marital Status Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: "natural", **Black** 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working nt of Health and Mental Hygiene.

It item 27 is marked other than or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Care Giver Services 12 Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First; Middle, Last) ပ Page 1 and 2 should be in ment of Health and Menta na Pansey Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosal Cauthen 812 Pleasant Hill Lane, Bowie, MD 20716 (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Birch Lawn Cemetery 12/1/2012 Giles, Virginia Signature of Funeral Service 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 04 a Ferry Road, Clinton, MD 20735 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Part 1. Ent eart fai Immediate Cause (Final Physician Hypertensive Cotonary disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 Month Day Year 5 Other (specify) Pregnant at time of death No the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? ρ Hyper tension 2No 3 Probably 4 Unknown 1 Yes Completed ongestive Heart 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed? page 2 s 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 L Yes 1 Inpatient 2 FR/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider iniury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of D46741 Jovember 26, 2012 (W) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D oachdeva

Registrar DHMH 17 Rev 7/2009

State

egistrar's Signat

28 201

11711 Livingston Road, Fort Washington, MD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Month towel Hampton 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mem cria Grace 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ★ M 2 □ F Days Hours Months Min 7777951 61 Yrs. 220-62-4434 Director MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖵 No MD Cecil Colora 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be i Funeral 2143 Colora Rd 21917 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Mechanic Trucking should be filed v and Mental Hyg æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leon Howell Ethel Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Lisa Little/ sister Rising Sun, MD 21911 116 Post Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/3/2012 Page 1 1XI Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nottingham West Colora, MD f Funeral Service Lice Name and Address of Facility
T. Foard Funeral Home, P.A. Signatur Oueen St. Rising 21911 Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each list. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perforn death? certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🖟 funeral 27. Manual of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 mordano 32. Registrar's Signature Date filed (Month, Day State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year Month **Physician** Rita Rose Hooper Nov 23, 2012 1:42 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Bradford Oaks Nursing Home Clinton nder 1 Year If Under 24 Hrs. If Under Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1□M 2□F Months Yrs 218 14-6193 Maryland Director Oct 13, 1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show other treumetic event, the Nedical Examiner , ust be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Brandywine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16415 River Airport road Items 23a 20613 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2770No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 X Divorced Year or Dates: "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Sales 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel Currera Katherine (unk) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Michael Hooper (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition , <u>=</u> 1 XBurial 2 Cremation 3 Removal from State 6 Department of Importent: If eny injury or one \*4 ☐ Donation 5 ☐ Other (Specify) Holv Redeemer Cemetery 11/28/2012 Baltimore, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signatu Fur ral Sirvice Licensee Ferry Road, CLinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Hamic OBSTILLTIUS Sequentially list conditions, it any, loading to finite class. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months?
1 Yes 2 240 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2 No Division of Vital To the Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No death. investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide after within 24 hours a To the Funerel ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36506 NNsmhu 23 2012 Times y

State Registrar

DHMH 17 Rev 1/2001

11701 Gringsh Road, Ft. Washington

completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

ANNERMO

11/100

NOV 2 6 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 839 PM Kuth 2013 vemb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical Center Baltimore University of 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 08/16/1927 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Director 1 □ M 2 🔀 F 227-24-2106 85 Virginia permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified an once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Pocomoke City 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 1732 Cedar Hall Road 21851 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 😾 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Retail Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey Hickman Carrie Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar Allen Hall/ Husband 1732 Cedar Hall Rd., Pocomoke, MD 21851 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
First Bapt. Cem. 1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/25/2012 Pocomoke, MD 22. Name and Address of Facility Holloway Funeral Home, P.A. Signature of Fune I Service Licensee m01129 107 <u>Vine</u> MD 21851 St. Pocomoke, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ espiratory disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner A550, entilator-Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a consiquence of ing physician and e as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: esn If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ō Month detached ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě lymphoproli 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate funeral director, pag 1 ☐ Yes 2 🛛 No 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation within 24 hours are dect To the Funerel Director completely filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Curtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67594 November 22, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

6

State

Hepp, MD

31. Date filed (Month, Day, Year) NOV 2 6 2012 South Greene Street

32. Registrar's Signature

10616

Balkmore,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ RICHARD JAMES HOLT 201 8:50 20 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN NURSING HOME BERLIN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 3-2-1938 1 💢 M 2 🗆 F DELAWARE 74 222-24-4456 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director r 28a-f sh notified 1 ☐ Yes 2 X No DELAWARE SUSSEX MILLSBORO 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a or ner must be r Funeral UNIT#10 28632 DUPONT BLVD US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item edical Examiner r 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status med Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 nours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.
27 is marked other than traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) OWNER/OPERATOR FURNITURE STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 of Health and Ments M. WESTON HOLT PAULINE LAYTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. AUDREY HARKINS/DAUGHTER 30705 FOXCHASE RD, SALISBURY, MD. 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial cemetery, crematory or other place, 2 Cremation 3 Removal from State ST. GEORGE'S CEMETERY 11-24-12 FRANKFORD, DELAWARE other (Specify) Ponation 5 MELSON FUNERALITY 43 THATCHER ST, Signature of EllitySERVICES, LT FRANKFORD, TD. DE. 19945 Part 1. Enter the d shock, or heart fai se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the t as 1 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? ţ Month Day Year Pregnant at time of death Unknown Yes 2 No be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page performed' certificate 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 🗶 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 2 XNo မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ▼ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Tes 2 🗌 No 24 hours after death. Funeral Director, A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of 29c. License numbe R 135131 November 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Savage, CRNP 9715 MD 21811 Pennie Healthway Dr, Berlin, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 Registrar

Richard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 1 Physician/ 2012 3:20p. Herbert Frank Harris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year **Funeral** 1 😡 M 2 🗆 F (Month, Day, Year) Mar. 8, 1935 Months Days Hours Min Director 213-34-8249 MD. Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director r 28a-f sl notified 1 Yes 2 No MD Worcester Berlin 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 ms 23a or must be r Funeral 21811 Chelsea Court USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11, Marital Status 12 Was Decedent Ever in U.S. Examiner Black, White, etc. or þ 1 Never Married 2 Narried 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: White "natural", Completed 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Bethleham Steel Industrial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be innent of Health and Menta Dorothy Dannenfelfer Herbert R. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Harris - Spouse Linwood Garth, Belair, MD. 21014 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Bel Air Mem.Gdns. 11-28-12 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William Street, Berlin, MD. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MINTHS disease or condition Medical resulting in death) Examiner MINTHS Sequentially list conditions, Examine if any, leading to mineciate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit O MONTHS DEEP VENOUS THROMBOSIS and Due to (or as a consequence of resulting in death) Last physician Physician/Medical P.O. Box 68760 the attending p for use as t IE FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES 24a Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page HYPERLIPIDEMIA 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year, 11-26-12 050924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIVISION ST. SKISRURY 1405 31. Date filed (Mor. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-f Per INF G934 12/20/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11/12/2012 12:15 P M Medical EUNICE R. HESS 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TALBOT WILLIAM HILL MANOR **EASTON** 7. Age (In yrs. last birthday, If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) Hours **Director** 234-26-0935 1 🗆 M 2 🗶 F Usual Residence of Deced 90 07/17/1922 WEST VIRGINIA 28a-f show 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Palm Beach County ₩D-FL Palm Springs CAROLINE 1 X Yes 2 No RIDCELY 10f. Zip Code 33461 ō 10e. Street and Number s 23a o, c must h 10g. Citizen of What Country? 316 Cavalier Road Funeral 105 WALNUT ST. <del>21660</del> USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, an "natural", or ite Medical Examiner Armed Forces?
1 ☐ Yes 2 X No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes, Give Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. tem 27 is marked other tha other traumatic event, the I 12 -0-OFFICE MANAGER GROCERY STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROSCOE RILEY MAMIE WILSON 19a. Informant's Name/Relationship DAUGHTER IN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DINAH A. HESS/ 105 WALNUT ST. RIDGELY, MD 21660 20a. Method of Disposition
1 X Burial 2 Cremation 3 Removal from State DORSEY/EART (VEne SMITH Department of Important: If it any injury or o FUNERAL HOME &CEMETERY 11/17/2012 LAKEWORTH, FL 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 2FRITAOWS: Greene LEEE ENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 MHOK 2 MERCER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death UROSEPSI disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) that initiated events burial-trar resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death signed by the a ld be detached f Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMENTIA CORONDRY BRITERY 1 Yes 2 No 3 Probably 4 Unknown RECENT MYDEARDIAL INCARCTION 24a. Was an Were autopsy findings available prior to completion of cause of autopsy • Hospital or Attending Physician: The 124 hours after death. • Funeral Director: After this certificate h 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ivatural
Accident
Suic 1 📉 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated RS 20

DHMH 17 Rev 06-2011

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		-	For State Registrar	State of Marylan		artment <i>tificat</i> e			na ivi		giene Reg. No	2 U 1	2 40143	
Physician/ Medical Examiner			Decedent's Name (First, Middle, Last)     Ola M. Harkins				2. Date 1 Month					12 Year	3. Time of Death 9:00 P M	
			4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital					4b. City, Town, or Location of Death Takoma Park				4c. County of Death Montgomery		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show the cary injury or other treumetic event, the Medical Examinating that the notified at once.	ted by Funeral Director	5. Social Security Number 6. Sex 428–32–4933 1 □ Usual Residence of Decedent	ist birthday) If Under 1 Year If Under 24 H Months Days Hours Mi				8. Date of Birtl 04 0 4 7		9. Bir Mi <sup>C</sup> S	thplace (State or Foreign unita) SISS ippi			
			10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limits   10d. Inside City Limits   1 \times 2 \to No											
			10e. Street and Number 581 9 Swarthmore Drive 20740						10g. Ci Un	og. Citizen of What Country? United States				
9800			11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ※ No If Yes, Give Year or Dates.			<ul> <li>13. Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 ☐ Yes ※XXNo Specify:</li> </ul>					14. Race - American Indian, Black, White, etc. Specify: White			
Baltimore, Maryland 21215-0036		Completed by	15. Decedent's Edu- (Specify only highest grade Elementary/Secondary (0-12)	(Give k	edent's Usual Occupation  kind of work done during most of working  NOT use retired)  Maker					16b. Kind of Business/Industry Own Home				
/land		To Be							(First, Middle, Maiden Surname) Mae Harrold					
, Man			19a. Informant's Name/Relationship (Type, Print) hter 19b. Mailing Address (Street and Number or Rural Rout) 5819 Swarthmore Dr. Bet						Route Number Berwyn	Number, City or Town, State, Zip Code) Wyn Heights, MD 20740				
imore			20a. Method of Disposition 1 □ Burial 2 ☆ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State MD CO	lace of Disponentery, crem Crema	sition (Name natory or oth LTION	e of her place C L :	ř. 1	1/25	ate 2012	20c. L Ha	ocation - City or nover,	Town, State MD	
Balt			21. Signature of Funeral Service Licensee	A-								Funer h, PA	al Home 15201	
	Pnysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Conset and Death disease or condition resulting in death)  a. Due to (or as a consequence of):								Interval Between			
0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  Due to (or as a consequence of):										
Division of Vital Records, P.O. Box 68760			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							1	23d. Date of de Month	livery Day Year		
ls, P.O			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Atu at Fibrillancow							23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
Recor										24a. Was a autop perfor	rmed?	prior to death?	topsy findings available completion of cause of	
/ital		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	26. Place of Death (Check only one)  Hospital:  1 Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Reside										
on of V		Medical Certificate: To	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work		y at 28		ne 5 Residence 6 8d. Describe how injury				
Division			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
			29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
			29b. Signature and title of certifier				29c. License number				29d. Date signed (Month, Day, Year)			
			Salyusauh Lar, MD  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SABYASACHI WAR  TAKOMA PARU, MD								<u></u>			
	W-O		SABYASACHI WAR TAKOMA PARU, MD							40				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 5:10pm Florence Elouise HARPER November 2012 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Fahrney-Keedy Memorial Home Boonsboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 22, 1916 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Months 1 M 2 KF 722-09-0686 95 Yrs Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 AYes 2 No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17960 Garden Lane 21740 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 XX If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify: white 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife her own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Charles Artz Susan Mae Mvers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Judith S. Dahlhamer - daughter 874 Frederick Street, Hagerstown, Maryland 21740 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 12/1/12 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Europeal Service Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 415 E. Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death Immediate Cause (Final extensil disease or condition resulting in death) to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last evely Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 SUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

attending physician and for use as the burial-tran

certificate has been signed rector, page 2 should be det

After this of funeral dire

within 24 hours are: \_\_\_\_ At the Funeral Director: Aft

To the Hospital or Attending Physician: The law requires that the death certificate be executed

O. Box 68760

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Division of Vital Records,

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**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any linury or other traumatic event, I'm Midical Expansion manual process.

Examiner Physician/Medical Completed by

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes 2 PNo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 → Natural

5 Pending

investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

21740

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

MD

29b. Signature and title of certifier

11-28-2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Waseem

31. Date filed (Month, Day, Year) MOA 8 9 5013

Court 32. Régistrar's Signature

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Beatrice Pearl Hibbard 13,2012 ovember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Hospital Prince George's Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) 436-52-4928 Director 72 1 🗌 M 2 🕱 F Jan. 4, 1940 Massachusetts Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Prince George's Glenn Dale 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò Hibbard, Beatrice Baltimore, Maryland 21215-0036 ms 23a or must be r 10g. Citizen of What Country? by Funeral 9918 Locust St. 20769 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Deceud... Armed Forces? ¹ ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: Completed White Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Psychotherapist Mental Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Theodore James Hibbard Jehovah Beatriz DeRivero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy B. Nagel / Son 12417 Madeley Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Metro Crematory 11/17/2012 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of): Due to (q Examiner 0 Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine requires that the death certificate be executed Cause (Disease or injury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the b IF FEMALE: nse : 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 Unknown the be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performe 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death ë 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. X Natural 5 Pending Certifical Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 0 2012

8118600dh

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1, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D62810

29d. Date signed (Month, Day, Year) 11/14/12

acked, laskam, MID. 20706

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2 Date of Death 3. Time of Death 5:28 PM Physician/ Month Dav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 3460 South River Terrace Edgewater Social Security Number If Under 1 Year If Under 24 Hrs. 7, Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 230-42-0772 1 X M 2 D F 2/6/1934 78 28a-f show 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Edgewater 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21037 USA 3460 South River Terrace "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married δ 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Account Executive Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elsie B. Boehme Edwin C. Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Mary Lou Hamilton/ Wife 3460 South River Terrace, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crematory 11/20/2012 Edgewater, MD 21. Sign of Jonera Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ BILE DUCTS METASTATIC CANCER OF Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): sician and burial-transit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed been si should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 autopsy perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Prysician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D

32 Registrar's Signature

SHAHID

NOV26

31. Date filed (Month, Day, Year)

D 14774

445 Defense Highway Annapolis, MD 11-20-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 10:00 P M November Carroll Winterson Hardesty, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 🗆 F 214-26-1905 12/27/1930 Maryland Director 82 Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Edgewater Anne Arundel 1 ☐ Yes 2 👿 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States ō ms 23a or Completed by Funeral 21037 510 Mayo Road "natural", or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 **X** No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give 3 → Widowed 4 □ Divorced White Year or Dates er than "natura", the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contracting alth and Mental Hygien 127 is marked other the traumatic event, the 9 Builder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Ella Dawson Marvin Hardesty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Eareckson Lane, Stevensville, MD 21666 19a. Informant's Name/Relationship (Type, Print) Carroll W. Hardesty, Jr./Son Department of Health Important: If item 27 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Lakemont Memorial Gardens 11/29/2012 Davidsonville, MD 4 Donation Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Year Day Pregnant at time of death ed by the a g Unknown g Unknown signed by Part II. **Other** si**gnificant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed? Yes 2 2 No certificate 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner' Hospita Other: 1 Yes ٥ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural s after death. 5 Pending work? 1 Yes 2 🗌 No Investigation Accident 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature at 29c. License number 29d. Date signed (Month, Day, Year) 123 of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

State Registrar

DHMH 17 Rev 06-2011

300

NOVEMBER

HARRIS

SHIRLEY

arkel

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signature

JUNECIA WHITE

NOV 2

31. Date filed (Month, Day, Year)

### **VOID**

# CERTIFICATE #

2012 - 40149

# SEE

# **CERTIFICATE #**

2012-39259

Michael Henderson

Completed 3-26-2013 WB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ tan 1e4 1456 M Henson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Bultimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Country **Director** 579-66-5296 1 M 2 □ F 62 Jan 22, 1949 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Prince George's Landover 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1907 Bellhaven Drive #302 20785 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒No Black, White, etc Š 1 X Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Unk Unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or not any inju ၉ pe Margaret Bobo 19a. Informant's Name/Relationship (Type, Print) Loughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Asia Henson/Shaneika Faison Featherwood Court #22, Silver Spring MD 20904 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/28/2012 Cremation Hanover, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tri-State Funeral Service, Inc Laternal 814 Upshur Street NW. Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Intracranial disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to lo as a consequence of): for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day signed by the at Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? s certificate has be director, page 2 s autopsy 1 ☐ Yes 2 No ☐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of eral Director: After filled in by the funer 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a
To the Funeral C Medical 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Monthy Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Box 68760

P.O.

Division of Vital Records.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Examin	er	4a. Facility Name (if not institution, give street	and number)		•	Location of Death		4c. County of Death		
A.	Funeral		27105 Acorn Drive  5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	_	lebron If Under 24 Hrs.	8. Date of Birth	9	OMICO  B. Birthplace (State or	Foreian
	Director		231-05-6096 <sup>1 □ M</sup>			Months Days	Hours Min.	10-4-19	Year) 17 We	country) est Virgin	ia
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	the M	Ē	10e, Street and Number			10f. Zip Code		1	10g. Citizen of Wha	at Country?	
	h with	Funeral	27105 Acorn Drive				1830		USA		
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Baltimore,	permit. Page 1 a Department of H Important: If its any injury or of		21. Signature of Funeral Service Licensee	016		Name and Addres			neral Ho		u
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20°1°2 November 6:05 A M Diane Carol Irwin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Caroline Denton Envoy of Denton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X**F Months Hours Min. 1011474952 Delaware 60 Director 215-62-1439 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r by Funeral 21629 USA 10591 Greensboro Road iral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 X Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disability Care 12 Nursing Home Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Edna Barney Herman Edwin Hignutt, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10591 Greensboro Rd. Greensboro, MD 21629 10591 Greensboro Rd. William Irwin, II/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Capitol Crematory 11/23/2012 Dover, DE 21. Si ure o Funeral Service uce 22. Name and Address of Facility Moore Funeral Home, 12 South 2nd Street Denton, MD 21629 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e ich line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital Other: ္ဝ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Matural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

29b. Signature and title of certifier

only one



within 2 To the I

10047534

29d, Date signed (Month, Day, Year) 2

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day Edward 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltima Northwest Hosp ital dallstour 5. Social Security Numbe 220 12 2546 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Director 87 10/12/1925 MD 10c. City, Town or Location at 10d. Inside City Limits Director Baltimore 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 pe by Funeral 6937 Glenheights Road 21215 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc ō 1 Never Married 2 K Married 3altimore, Maryland 21215-0036 27 is marked other than "natural", or traumatic event, the Medical Exan 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 🗌 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Private 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fannie Wilson Jared Jameson 19a. Informant's Name/Relationship (Type, Print)

Marsha Jameson/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6937 Glenheights Rd. Baltimore, MD 21215 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State All St.Episcopal Cem. 11/24/2012 4 Donation 5 Other (Specify) Avenue, MD 21. Signature of Funeral Service Licenser 22. Name and Address of Facility Briscoe-Tonic Funeral Home 38576 Brett Way Mechanicsville, MD 20659 23a. Pm 1. Enter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, six ck, or heart failury. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition mystocha mound Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an Inum prior to completion of cause of death? 2. No 1 Tyes completely filled in by the funeral director, Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No. Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital of within 24 hours a To the Funeral D Medical 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D0056632 who completed cause of death (Item 23a) (Type, Print) 5401

Registrar DHMH 17 Rev 06-2011 Registrar's Signatu

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar  1. Decedent's Name (First, Middle,	Last)		007	incare or E	Jean	T :	2. Date of Dea	Reg. No. ath	1201		3. Time of Death
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1	Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, or	r Location of D	eath			County of De	eath	1000
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and	show	ا ا	10a. State 10b. County			y, Town or Lo	ation			1,120,1	,	1,,,,,,		d. Inside City Limits
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Saltimore, permit. Page 1 and Department of Hea	Important: If the ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li		FL.		. Name and Addres							
	E E E		Donya Man	gomey. G	reated		401 Blade							20722
			23a. Part 1. Enter the disease, or a shock, or heart failure. List or			h. Do not ente	r the mode of dyin	g, such as card	diac or r	espiratory arr	est,			Approximate nterval Between
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<b>BOX</b>	the at hed fo	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregn 9 ☐ Unkno	ant at time of cown	death 5∟	Other (specify)					Month	D	ay Year
at the	detac	, Ph	Part II. Other significant condition	ns contributing to de	ath but not res	ulting in the u	nderlying cause giv	ven in Part I.		23e. Did to	bacco us	se contribute	to the	cause of death?
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JIVISION OI al or Attending PI s after death.	Direc I in by	Certificate:	4  Homicide determi	ned 28e. Place o	of Injury - At ho g, etc. (Specify	me, farm, stre	eet, factory, office		28	f. Location (S City or Tow		Number or F	Rural R	oute Number,
DIVISION OF VITAL RECORDS, P.O. BOX 08/00  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: Affer completely filled in by the funer		29a. Certifier 1 Certifying	Physician: To the be	st of my knowl	ledge, death o	occurred at the time	e, date and place	ice, and	due to the ca	use(s) an	d manner as	stated	
n 24 h	le Fur	Medical	(Check 2 Medical Ex	kaminer: On the basis Nurse Practitioner:	of examination	and/or invest	igation, in my opinic	on, death occurr	red at th	e time, date a	nd place,	and due to th	e cause	e(s) and manner stated.
To th within	To the		29b. Signature and title of certifier				29c, License	number			29d. Date	signed (Mo	nth, Da	y, Year)
			11/2 191	)			4	7867				13/20	12	
5	Fin His		30. Name and address of person w	ho completed cause	of death (Item	23a) (Type, P		die 211-		11 71	000	>		
			(IN Day July 30	4701 PR	naclph		up. 100	CRUIUA	4, 1	is a	070			
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			0 10	4		. //								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Kwitkoski Walter Nov 20, 2012 6:43 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7902 Hasting Lane Clinton Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 146 14 1303 87 Director 1 XM 2 □ F Jan 5, 1925 New Jersey ir than "natural", or itams 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Prince George Clinton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 7902 Hastings Lane 20735 United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Types 2 No
If Yes, Give
Year or Dates. Korean Black, White, etc. 1 Never Married 2 Married ≥ Maryland 21215-0036 hours after 1 ☐ Yes 2 XXNo Specify. Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 parmit. Paga 1 and 2 should be filed within 72 Dapartmant of Health and Mental Hygiana Important: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) <u> Aircraft Parks Logistist</u> Dept of Denfense Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Kwitkoski Zelinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sophie C. Kwitkoski (Wife) 7902 Hastings Lane, Clinton, MD 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Feb 7, 2013 Arlington, Virginia 21. Signatur f Funeral Service Licens 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death cartificate be exacuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be deteched for use as the burial-transit Exam Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 4 Pregnant at time of death ∐Yes 2 🗆 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [조 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 N **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? v 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 1 Whatural 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No 2 Accident Investigation Suicide
Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kouertchou, MD 563748 Joce Eyne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kouccitchou, MD 4041 Powder Mill Road, Calverton, MD 20705

State Registrar 31. Date filed (Month, Day, Year)

NOV 282012

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:19 P м JAMES GEORGE KENDALL, JR. November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carrol1 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 220-42**-**0400 Director 1 🖾 M 2 🗆 F July 31 1943 69 MD Usual Residence of Decedent 10a. State 10b. County is than "neturel", or items 23e or 28a-f sho the Medical Examiner must be northed at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after deeth with the Maryland Director 1 Yes 2 No Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7221 Honey Bush Dr. 21771 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗌 No Black, White, etc. Ŕ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1962–68 1 ☐ Yes 2 No Specify Specify: Completed 3 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) carpenter/mason U.S. Government permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Importent: If Item 27 is marked othe eny injury or other treumetic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James G. Kendall, Sr. Agnes M. Griffiths 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Kendall/wife 7221 Honey Bush Dr., Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Olive Cemetery Mt. 11/24/2012 Mt. Airy, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. . Signature of Funeral Service Licenses Ridgeville Blvd. Mt Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition ears Medical resulting in death) Due to (or as a consequence of): Éxaminer Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi) To the Hospitei or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate hes been signed by the ettending physician end completely filled in by the funerel director, page 2 should be deteched for use as the burlal-trensit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? (è Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 8b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

29b. Signatur

30. Name and address of

nd title of

ertifier

1. GILSON

DHMH 17 Rev 06-2011

GUILFORD DR

FREDERICK MD 21704

son who completed cause of death (Item 23a) (Type, Print)

32 Pegistrar's Signature

MERCHA

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 23a, tchd, 11/15/12, rs Amended Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 10. WILLIAM H. KINLOCK, III 2012 3:04 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CANDLE LIGHT COVE EASTON TALBOT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 216-14-9879 Director 1 X M 2 □ F 91 MAY 5, 1921 NEW YORK Usual Residence of Decedent Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "hadical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director TALBOT MD EASTON 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 WEST EARLE AVENUE 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes. Give 3 X Widowed 4 □ Divorced Specify: WHITE Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ENGINEERING ASSISTANT TELECOMMUNICATIONS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM H. KINLOCK, JR. NAOMI JANE RIPLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6922 THORNETON ROAD, EASTON, MD STEVEN F. KINLOCK, SON Baftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 X Burial 2 Cremation 3 Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PK 11/17/2012 EASTON, MD 21. Signature of Faneral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
200 SOUTH HARRISON STREET, EASTON, MD 216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death, Physician/ AI disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir Organic Brain <del>Dji</del> Disease years burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atten for u in the past 12 months? signed by the at id be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Records, hyperpain 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\blacksquare$  Other (Specify) ASST.LIVING 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No. I Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number CRNV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month,

BOTKIN

strar's Signature

Commune Du #106, Easton, Md 2/601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 11/06/2012 Year **Physician** 10:20 RICHARD LEE KELLER Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT WILLIAM HILL GARDENS EASTON 8. Date of Birth (Month, Day, Year) 11/24/1926 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours 1 ☑ M 2 ☐ F WASHINGTON 533-20-1050 85 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Item Medical Ever it and country to native the native of the standard of the 10a. State 1 XYes 2 No Director EASTON MD TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 USA 545 CYNWOOD DR. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∭Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) UNITED AIRLINES PILOT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MILDRED HURD 2 EUGENE J. KELLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 328 PERRY CABIN DR. ST. MICHAELS, MD 21663 PATRICIA W. KELLER/WIFE 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition *(Name of* CHESAPEANEON OREMATENON 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CENTER STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 11/9/2012 2F WING ON Store HETER HONBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 200 S. HARRISON ST. EASTON, MD 21601 WOHNR. MERCERON Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Aspiration disease or condition resulting in death) /Medical Due to ( as a consequence of): Examiner Vascular Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.0. sate has been signed by the page 2 should be detached in 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed 2 No 1 □Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Asc+ Facility 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Patter death.

Director: After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RO77623 11-6-12 L. ShameaNI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 545 Cynwood Drive Easton RS/2+11/A Thomas 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV

12-08683

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cheryl Lynn Knick State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Physician/ Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Medical Examiner** 2027 hrs November 15, 2012 CHERYL LYNN KNICK 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Baltimore Harbor Hospital Center BALTIMORE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State or **Funeral** Foreign ANNAPOLIS Months Days Hours Min. Director 08/10/1955 57 2 X F 220-66-5015 1 M Yrs Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No 28a-f show MARYLAND ANNE ARUNDEL BROOKLYN PARK Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Heath and Mental Hygeine.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f who. , or items 23a or 28a-f short must be ootified at ooce. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 UNITED STATES 5110 BROOKWOOD ROAD Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 8lack, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. 1 Never Married 2 Married 2 X No Yes Specify: WHITE f Yes, Give Year 3 X Widowed 1 Yes 2 X No specify: 4 Divorced ۾ or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GROCERY CASHIER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be BETTY ROSE WALTER WILLIAM HUDSON ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 MEADOW RD. RIVA, MARYLAND 21140 STEPHEN JASON ATKINS / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) EPIPHANY EPISCOPAL 1 X Burial 2 Cremation 3 Removal from State 11/21/2012 ODENTON, MARYLAND Donation 5 Other Specify CEMETERY 21. Signature of Funeral Service Licenser 22 Name and Address of Facility
HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE
814 BESTGATE ROAD ANNAPOLIS MD 21401 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and failure. List only one cause on each line Modreal Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Discass or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) icate has been signed by the atterpage 2 should be detached for a 1 Yes 2 V No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? After this certificate ✓ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physiciae: within 24 hours after death.

To the Fuocral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes ဠ 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification Nov 15, 2012 Pedestrian struck by auto 1 Natural 1944 hrs 1 Yes 2 ✓ No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) S/B Ritchie Hwy South of 11th Avenue, Brooklyn Park determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Wedical** 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. November 16, 2012 80. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

34

31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Philip Wayne november 21 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbut Salisbury wicomiosin Kehab Nutsing Center MD . Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yr last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 092-30-9918 Director 1 🔀 M 2 🗆 F 71 04/19/1941 New York Usual Residence of Decedent 10a. State 10b. County with the Maryland event, the Madical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No Maryland Wicomico Salisbury 23a or 3 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 200 Civic Ave. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiler mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 1 Tes 2 No Specify: 3 Divorced 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 4 Probation Supervisor Livingston County, NY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth (unknown) William Peter Klos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary R. Klos/Spouse 8212 E. Desert Trail, Mesa, AZ 85208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State 11/26/2012 4 Donation 5 Other (Specify) Salisbury Crematory Salisbury, MD Signature of Fun ral Service Licensee 22. Name and Add Holloway and Address of Facility Dway Funeral Home Professional Association , Salisbury, MD 21804 Rd Monday snow Hill 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onser and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Hospitai or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title DIC who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M		Dep		t of H	lealth			giene	0010	401	62
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(0	or iter	y Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 X Married</li></ul>	12. Was Decedent Armed Forces? arried 1 🗆 Yes 2 🔀							cify Yes or No- Rican, etc.)		14. Race - Americ Black, White,		
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Maryland	2 shouth and 17 is mutanm	19	19a. Informant's Name/Relation		1		_						Town, State, Zip	Code)	
	and and tem 2		Jeffrey F. Kin 20a. Method of Disposition	inamon (Husba	20b. Place of				Rd.,		ely, MI		1660 ocation - City or To	wn State	
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5			30. Name and address of person	who completed cause of d	eath (Item 23a) (1	722 722	Sou	ar (	Alun	le S	T, BA	271mg	no MD	21201.	
	Stat Registra	е	31. Date filed (Month, Day, Year)		r's Signature		See Al	J			<del>,</del>		/		
				A Committee	199	1	Cally Also are an								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Decomber Physician/ William E. KRATZER Day 2 2:48 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington 55 East Washington Street Hagerstown 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Year 1932 79 Yrs. Dec. 31, 200-24-9060 Pennsylvania Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Washington Hagerstown 1X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral 21740 55 East Washington Street Apt 1009 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🖾 No Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) self employed retail sales traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Anna Ramer George William Kratzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candice Evans - niece 8138 Buena Vista Drive, Rome, New York 13440 other 20a. Method of Disposition 20b. Place of Disposition (Name of ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ò 4 Donation 5 Other (Specify) injury Signature of Funeral Service Licensee any inj once, 23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ affery stonary disease or condition Jean Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Die to (or as a consequence of resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Unknown signed by the a Id be detached f Yes 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Dulmonat Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed Yes 2 death? Chronic Kidney After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X-No Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **™**Natural 5 Pending 2 🔲 No Investigation 6 Could not be Accident filled in by the Director: Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical

within 24 hours a

State Registrar 29a. Certifier

only one)

29b. Signature and title of certifie

31. Date filed (Month, Dav. Year

Theth

who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November<sup>Day</sup>19 2012 10:21AM Ruth Naomi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Frederick Frederick Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 216-22-1838 Director 1 □ M 2 🗓 F JAN.5,1929 Maryland 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified et Director Maryland Frederick Frederick 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21702 1403 A, Key Parkway, # 202 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural" Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lih and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Draper Crone Edgar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 is 3014 Dunmurray Rd./ Baltimore, MD Richard Lakin / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Cem . cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State Cavetown Church Christ 11/24/2012 4 Donation 5 Other (Specify) |Cavetown,Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, P.A. 1621 Opossumtown Pike/Frederick, MD 21702 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. artorioschritic Immediate Cause (Final Onset and Death Physician/ and 10 vas le disease or condition resulting in death) par Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). After this certificate has been signed by the attending physiclan and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death P.O. Part II. Other significant conditions contributing to death both not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/19 D09689 12 9/12

State Registrar

DHMH 17 Rev 06-2011

FREDERICK, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

AUSTIN PEARRE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov 20, 2012 Arthur Μ. Longacre 3:06 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collington Episcopal Life Care Mitchelleville Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 187 05 6456 Director 95 1 XX/12 □ F Yrs July 30, 1917 Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Mitchellville 10e. Street and Number ō 10g. Citizen of What Country? of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 10450 Lottsford Road # 2210 United States permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Air Force 12 Retired Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David S. Longacre Lottie Mohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t; If item 27 is y or other trai Harold William Howard (Nephew) <u>3251 Mary Drive, Marietta, Georgia 30066</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Importants If any injury or once, Lee Crematory Nov 23, 2012 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature of Funeral Service Licensee Ferry Road Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ heart Congestive disease or condition resulting in death) 4ear Medical **Examiner** Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ obstructive + restrictive pulmonar 1 res 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

only one 29b. Signatur

-mo

erson who completed cause of death (Item 23a) (Type, Print)

022780

7500 Greenway (tr. Dr. Greenbelt, MD 20770

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November IRIS PAULINE LIEBIG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital at Easton EASTON Memoria TALBOT If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours SCOTLAND 03/01/1923 Director 084-18-3818 1 🗆 M 2 🗶 F 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 ื No **EASTON** MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8910 TEAL POINT RD. 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, efc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) REGISTERED NURSE HOSPITAL 12 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ JOHN MORTIMER CATHERINE GORDON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8910 TEAL PT. RD. EASTON, MD 21601 C.J. LIEBL/DAUGHTER Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAR KAKERY CREMATE ON 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) CENTER 11/9/2012 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 4 Price OWS derent FENBEIN & NEWNAM FUNERAL HOME, P.A. IOHN 200 S. HARRISON ST. EASTON, MD 21601 MERC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to lor as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☑ Unknown Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 7 24 hours after death. Funeral Director, After this certified filled in by the funeral director, 25. Was case referred to medica æ 26. Place of Death (Check only one) 1 Yes 2 မ 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ×\$65656 30. Name and add who completed cause of death (Item 23a) (Type, Print) ress of perso 2  $\subset$ 

State

Registrar

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32. Registrar's Signature

		Plea	ase Type or Pr			ndelible Inl artment of F		-		•		
	•	For State Registrar	Glate of IV	nai yiai ic	,	tificate of L		Montanin	Reg. N	0016	10167	
Dh i a i a	.,	1. Decedent's Name (First, Middle	e, Last)					2. Date of De	eath	Sum To 2 To	3. Time of Death	
Physiciai Medic		naven		(	an	en				ay Y 23 201		
Examine	er	4a. Facility Name (if not institution	n, give street and number) Lutheren	Villag	P	4b. City, Town, or	Location of Death			c. County of Dea	nation	
Funeral		5. Social Security Number		ge (In yrs. Vas		If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Bi	rthorace (State or Foreign	
Director		073-14-1096	1 □ M 2 🔀 F	96	Yrs.	Months Days	Hours Min.	(Month, Di			cway	
show at	P.	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation		37 237			10d. Inside City Limits	
Maryla 28a-f s	Director	MD Wash:	ington	Hag	gersto	wn					1 🔏 Yes 2 □ No	
ith with the Maryland ms 23a or 28a-f show must be notified at	ا <u>ت</u>	10e. Street and Number			-	10f. Zip Code			10g. C	itizen of What C	ountry?	
ms 23 must	Funeral	1158 Luther Dr:	ive	Frenia II C	10.10	21740 Vas Decedent of Hi	ionenia Origina (Ca	anifi Van ar Na		U.S		
ter o	ह	<ul><li>11. Marital Status</li><li>1  Never Married 2  Mar</li><li>3  Widowed 4  Divorced</li></ul>	Armed Forces	?	If	Yes, specify Cuba	n, Mexican, Puert			14. Race - Ame Black, Whit Specify: Wh:	te, etc.	
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be fill lental rked c	ᅙ	Lars Heisel La	<i>'</i>					Jensen	, maiden	ourname)		
should and M is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numb	er, City o	r Town, State, Z	ip Code)	
nd 2 s lealth m 27 ner tra	ļ	William Camp /	Executor			Quail Run	Road, K	Cennett	_			
ge 1 a nt of H :: If ite or otl		20a. Method of Disposition  1 Burial 2 Cremation		e cei	metery, crem	sition (Name of natory or other plac		Date		_ocation - City o		
artmer artmer ortant injury	- 1	4 Donation 5 Other (3	<u> </u>	Rest		n Cemete					, Maryland	
permi Depar Impol any ir		Thea An	- Brand	ent	A - 4	01 Penns					•	
Physician/ . Medical		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	r complications that cause only one cause on each lir	ed the death.	Downt ente	r the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Examiner  ausit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	UTRIS a conseque	ince of):	en nion	dise	ale_				
exectian an	쁘ㅣ	resulting in death) Last	Due to (or as	a conseque	nce of):	7,0						
ate be chysic the bi	<u>ğ</u>		d									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 Fetal at time of de	death 3 🗌	Ectopic pregnanc	у			23d. Date of de Month	elivery Day Year	
uires that t n signed b uld be dete	<u>ا ۾</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to 1 yes 2 No 3 pr									o the cause of death? Probably 4 🗌 Unknown	
w req	Completed	24a. Was an autopsy								itopsy findings available completion of cause of		
The la ate ha	E								ormed?	death?	s 2 No	
ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (Che	ck only one)				
Phys	유	1 ☐ Yes 2 ☒ No  27. Manner of Death	1  Inpa	tient 2 E	R/Outpatien:	t 3 🗆 DOA	4 Nursing F			6 Other (Spec	cify)	
ttending death. stor: Afte y the fune	Certificate:	1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	ng (Month, Da gation not be 28e Place of In	ay, Year)	Injury work?  M 1 Yes 2 No					be how injury occurred		
pital or A												
n 24 h	Medical	(Check 2 Medical I	Examiner: On the best of Nurse Practitioner: To the	examination a	and/or investi	gation, in my opinio	n, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner state	
To the To the comp		29b. Signature and title of certifie			3,7	29c. License				ate signed (Mont		
		Lahred	! Tahman	)		10	00632	-33	/	1/26/	2012	
	- 1	20 Name and address of person	who completed cause of	death (Item 3	3a) (Tyne D	rint\				1 (	3.7600	

DHMH 17 Rev 06-2011

State Registrar

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	_ State	ryland / Depa Cer	artment of He tificate of D			ene eg. No. 2	1.0	Entro	
			1. Decedent's Name (First, Middle, Last)	Catr	2. Date of Death	3. Time of Death					
aler.	Physicia Medio	al	Ethel Katherine Lagerhauser			Novemb			2:40PM		
-	Examin	ier	4a. Facility Name (if not institution, give street and number)  Meritus Medical Center		4b. City, Town, or the Hagerst			4c. County of Death  Washington			
	Funeral Director			(In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 16	birth 9. Birthplace (S Day, Year) 10,1927 Illinoi:		ace (State or Foreign	
	yland f show ed at	tor		10c. City, Town or Loc Hagerstow					100	d. Inside City Limits	
	he Mar or 28a- e notifi		10e. Street and Number	Tiage15tow	10f. Zip Code		11	Og. Citizen of W	/hat Countr	1 X Yes 2 No	
	n with t	Funeral	643 Observatory Dr.		21742			U.S.A.			
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Event Forces?  1 □ Yes 2 ☒ N  If Yes, Give Year or Dates.	er in U.S. 13. W o 1	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 X No	, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036	72 hour n "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupat	tion uring most of worki	ng	16b. Kind of Bu	siness/Indu	stry	
	within giene.		Elementary/Secondary (0-12) College (1-4 or 5+		NOT use retired) maker			Domes	tic		
Maryland	should be filed within 7 n and Mental Hygiene. 7 is marked other than raumatic event, the M	To Be	17. Father's Name (First, Middle, Last) Albert Krueger			18. Mother's Name Augusta	(First, Middle				
Mary	12 should be lith and Ment <b>27 is marke</b> r traumatic e		19a. Informant's Name/Relationship (Type, Print)  Kathryn E. Palmer-daughter		g Address (Street ar Wood Tor				ate, Zip Co	de)	
Baltimore,	(1) O year 2		20a. Method of Disposition  1       Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem McHenry	sition (Name of patory or other place Lounty Men	n. 12-1		Noodsto	-		
Balti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	22.	Name and Address	of Facility DOL	glas A. North Ha	Fiery agersto	wn, M	al Home D 21742	
r	HH		23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.	000					4	Approximate Interval Between	
	Medical		was ulking in death)	TE H	POXIC	PES	PIRAT	lure	-	Onset and Death	
W	Examiner		ANIO	xic F	INCEF	EPHALOPATHY					
	ted I ansit	Examine	cause. Enter Underlying Cause (Disease or injury	consequence of):	BRILA	TION	WITH	PAPI	-0		
	cate be executed physician and s the burial-transit	al Ex	that initiated events resulting in death) Last	consequence of):	16 CART	5	TNE	175012	T E		
3760	ficate b g physi as the t	Medical	d. /1001		jo en jo i	J/1+C .	+ 10/1+	rec (ce.			
. Box 687	The law requires that the death certificate be executed attending physician and page 2 should be detached for use as the burial-trans	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery oth D	/ ay Year	
ds, P.O.	quires that then signed by	۵	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause give	n in Part I.				cause of death?	
of Vital Records,	s <b>ician:</b> The law rec certificate has be lirector, page 2 shc	Completed					24a. Was an autopsy perform 1  Yes 2	ped?		y findings available pletion of cause of	
Vital	ysician: s certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital: Inpatien	t 2 ER/Outpatient	Other	e of Death (Check	only one) me 5 ☐ Resider	nce 6 🗆 Other	r (Specify)		
n of	ding Phys h. After this funeral di		27. Manner of Death 1	28b. Time of	.28c. Injury a work?	at :	28d. Describe hov				
Division	or Atten ifter deat irector: in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.	r - At home, farm, stre (Specify)			28f. Location (Stre City or Town,		r or Rural R	oute Number,	
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of m (Check 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practitioner: To the last of t	mination and/or investi	igation, in my opinion	, death occurred at	the time, date and	place, and due	to the cause	e(s) and manner stated.	
	To th within To th comp	<	29b. Signature and title of certifier	11	29c. License			d. Date signed			
	11.10		30. Name and address of person who completed cause of dea	ith (Item 23a) (Type, Pr	rint)	10001		11/03	110	21742	
	ルーl ス Stat	0	Kamesh Kunak My 31. Date filed (Month Per Year) and 32. Registrar	Signature	Medica	l Camp	ous Kd.	Hages	stow	n, ins	
	Registra	e e	NUV \$ 5 ZUIZ	4	ALCON TO THE PARTY OF THE PARTY						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Edward De Hart Laird 2012 4:15 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heartfields Assisted Living Easton Talbot If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 186-20-8893 **Director** 1 X M 2 □ F 85 04/26/1927 Pennsylvania permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Talbot Easton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 Port Street Building 100 21601 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces: Black, White, etc. 1 Never Married 2 X Married Completed by 1 **X** Yes 2 □ No **1945** − If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 Divorced Specify: White 1946 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Master Mechanic Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Russell Laird Maude Eliza Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Laird / Son 109 Kirwans Landing Lane, Chester, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Allegheny Cemetery 11/24/2012 Pittsburgh, PA 21. Signature of Funeral Service Licenses Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 No 2 🗌 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 C Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Q Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one 3 Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 31. Date filed (Mor 32. Registrar's Signature State 2012 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Sarah 3:05 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince Future Care Pinevie Clinton George's 5. Social Security Number Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 🗆 M 2 🔀 F Columbia, S.C 10/05/1921 Director 579-30-6972 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shorexaminer must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 ☐ No Md. P.G. Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9106 Pineview Lane 20735 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian or i Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th Domestic Private Homes marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ပ္ Jack Moye Bessie Williams injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Khisa S. Lee/Granddaughter # 52 S St., N.W., Washington, D.C. permit. Page 1 and 2 Department of Healt Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/24/2012 Harmony Mem. Park Landover, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. Snatt CC0316 4925 Burroughs Ave. N.E. Washington D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Physician/ neumonia disease or condition Medical resulting in death) s a consequence of) Examiner ementia Sequentially list conditions, If any leading to it mediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical attending philor use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year signed by the a d be detached f 1 ☐ res ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law certificate has pade performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Ma of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 🔲 Pending Natural
Accident
Suicide
Homicide ours after death.

neral Director: Aff 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature al 45M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 Md 20735 Pine view Liene 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Box 68760

P.0.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 21, 2012 1214 Lawrence Douglas Lattisaw Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) **Director** 218-16-0118 1 🖾 M 2 🗆 F 89 23, Maryland permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show enty injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🖳 Yes 2 🗌 No Upper Marlboro Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14403 Croom Airport Road 20772 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Painter Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Lattisaw Rose Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1409 Hancock Place Upper Marlboro, Md. Marylin Douglas - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter), crematory or other place)
Mary Land Veterans
Cemetery 20c. Location - City or Town, State Datoth Nov. 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John T- stewart M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fata Onset and Death Physician/ Carchae assythmia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospitel or Attending Physician: The lew requires that the death certificate for execution within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Decubitus 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Detrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier Ju MI Joen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month. Day.

Cheventy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29c-d, per MD 2942 8/8/13 TRT
State of Maryland Department of Health and Mental Hygiene 2 | | 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LEWIS LOIS В. 2012 NOV. 9:10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WICOMICO WILLARDS 36431 HEARN ST. 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, NOV • 27 • 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months 91 1920 MARYLAND Director 21.8-16-5197 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND WICOMICO WILLARDS 1 X Yes 2 □ No 10e Street and Number ò 10f, Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be Funeral 36431 HEARN ST. 21874 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural". 3 X Widowed 4 Divorced Specify: WHITE Completed the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 72 } (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURING 12 SEAMSTRESS other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ' Is marked of မ BAKER Ε. DAVIS **GEORGE** W. MARY permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7325 DIVISION ST., WILLARDS, MARYLAND 21874 PATRICIA A. MASSEY/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/26/12 PITTSVILLE, MARYLAND 4 Donation 5 Other (Specify) PITTSVILLE CEMETERY Funeral Sejvice, Lice 21. Signat 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ ASCVI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Examin and I-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 phys nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? for Month Day Year Pregnant at time of death Yes 2 No Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' death? certificate 2 🖸 N Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? \_2 🗹 No 5 Residence 6 Other (Specify) 잍 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 4 hours after death. uneral Director: Aft ed filled in by the fur 1 Tes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August 5, 2013 D47094 310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. My 20804 NATERAN Hermon SACISBURY 9514 Ve 31. Date filed (Month egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 17 nd Physician/ 10:43 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Souther intor ML 5. Social Security Number Birthplace (State or Foreign Country) (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral Director** 379-26-1742 1 □ M 2 👿 F 6-1921 Mississippi other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland orit 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral Belt 2021 20744 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🐼 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify. If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Murse Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F 2 Page 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 2021 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20607 23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Pnysician Ardio disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Exami doys sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 X No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D0052865 Ba-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn Oale MO Ste 200 12150 Annappeles Rd FIGARO

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 2012 10:30a M Nov. 22 Gary Arthur Munneke Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Elkton Union Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Birth Social Security Number **Funeral** Days Hours (Month, Day, 2/29/ 1**∑** M 2 □ F Yrs. Director <u>64</u> 449-86-4533 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No MD Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21901 5409 Turkey Point Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Law Professor Law School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Leslie Munneke Margaret Coe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sharon Walla /</u> wife Main St. Elkton, MD 21921 157 Ε. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 11 4 ☐ Donation 5 ☐ Other (Specify) Foard Funeral Home, Rising Sun, Signature of Euneral Service Licensee .T. Foard Funeral Home, P.A E. Elkton. 59 Main St. Z3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final Physician/ forc Hou resulting in death) Medical Due to (or as a conse vence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal deat
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) 22/2012

(19)

State Registrar

10+1VA

Jason

Bon

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32. Registrar's Signature

21921

GIKAM, MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marthews

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20b per FH FCHD TM 11/27/12
State of Maryland / Department of Health and Mental Hygiene 2 0 2 40175 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 24, 2012 Naomi Marguerite McMurry 7:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 515 Valley Street Frederick Frederick 8. Date of Birth
(Month, Day, Year)
July 19,1926 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land **Funeral** Months Days Hours 220-16-4095 Director 1 □ M 2 🂢 F 86 2 should be filed within 72 hours efter deeth with the Merylend thend Mantel Hyglene.
27 is marked other then "neturel", or items 23e or 28a-1 show traumetic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 Valley Street 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. Black, White, etc. ۵ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specity: White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Automotive Insurance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lewis Hildebrand Gladys Orme 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10405 Pleasant Vista Dr., Frederick, MD 21701 and 2 s Haelth John L. McMurry (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Pege 1.
Depertment of P
Important: If its
any injury or of
once. 1 Burial 2 Cremation 3 Removal from State Mount Olivet Cem. Frederick, Maryland 4 Donation 5 Other (Specify) 11/29/2012 Name and Address of Facility
eeney & Basford P.A. Funeral Home
06 E. Church St., Frederick, MD 21701 21. Signature of Funeral Service Licenses MO1612 elosar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition Storchitis Onset and Death Physician/ sth matic Medical resulting in death) Due to (or as a consequence of): Éxamine Brochiectasi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the ettending physician end hed for use as the burlal-trensit Exami The lew requires that tha deeth cartificete be axecuted Cause (Disease or injury that initiated events resulting in death) Last Calil'Se Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 ANo
9 Unknown Month sete hes been signed by the epoge 2 should be deteched P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ allows of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate 1 ☐ Yes 2 SANo 1 ☐ Yes 2 ☐ No funaral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home S Residence 6 Other (Specify) 1 ☐ Yes 2 ANo ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred al or Attending F s efter deeth. I Director: After t 1 Natural 2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No the Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide To the Hospital or Atte within 24 hours efter der To the Funeral Director completely fillad in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11 Zanihe 24/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha Pierce, MD, 300 W. 9th Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) NOV 2 6 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOV . Benjamin Prince McRae 2012 12:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Gilcrest Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 224 50 8404 Country) Director 1 ☑ M 2 ☐ F 72 NC 12/08/1939 "neturel", or items 23a or 28e-f show solical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours efter deeth with the Maryland 10d. Inside City Limits Director Roslyn Montgomery 1 Yes 2 No 10f. Zip Code 19001 10e. Street and Number 10g. Citizen of What Country? 2461 Susquehanna Road 1st Floor Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ei Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Football Player Be permit. Pege 1 and 2 should be filed Department of Health and Mentei Hy Important: If Item 27 Is merked oth eny injury or other treumetic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Helen Davis Neal Archie McRae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kellan McRae/ Daughter 2461 Susquehanna Rd.1st Floor Roslyn, PA 19001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/30/2012 | Hampton, VA 4 ☐ Donation 5 ☐ Other (Specify) Hampton Mem.Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityO.H.Smith &Son Funeral Home 3009 Chestnut Ave. Newport News, VA 23607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) <sup>'</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami or Attending Physicien: The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated events nding physicien end use es the buriei-tren resulting in death) Last Due to (or as a consequence of): sate hes been signed by the ettending physicien page 2 should be deteched for use es the burie Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Dav ∐Yes 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate To the Hoepitel or Attending Physicien: within 24 hours effer death.

To the Funerel Director; Affer this certifics completely filled in by the funerel director; 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No pice ျ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ed cause of death (ftern 23a) (Type, Print)

Registrar

State

egistrar's Signatum

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 November 12:50 PM <u>Rose Marie Mularski</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death LaPlata Charles Civista Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Numbe **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Min Director 394-22-5281 1 🗆 M 2 🗶 F 85 November 11, 1927 Wisconsin ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director X Yes 2 No Maryland | Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? Funeral <u> 20603</u> USA 8680 Courtney Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) House wife Own Home 8th. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Czieslewicz Henry Ulick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 8680 Courtney Dr. Waldorf, Maryland 20603 <u>John Mularski/ Son</u> 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specifiv) Huntt Crematory Nov. 21, 2012 Waldorf, MD. 21. Signature of Funeral Service Licen 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that be used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. MYOCARDIAL INFARCTION Immediate Cause (Final Onset and Death Physician/ M disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death signed by the a 2 X No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CWSION 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: ပ 1 🗌 Yes 1 Inpatient 2 KER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a D 28281 npleted cause of death (Item 23a) (Type, Print) CNICRS 913( F

State Registrar

DHMH 17 Rev 06-2011

PISCATAWAY RD CLINTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LUVENIA SPRIGGS MONTGOMERY 241 MARGARET Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **CTRHARWOOD** ANNE ARUNDEL MANDRIN HOSPICE HOUSE INPATIENT CARE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 78 **Director** 214-30-2294 1 🗆 M 2 🛣 F JUNE 21,1934 MARYLAND ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10b Count 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND 1 Yes 2 No CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 20640 6445 MASON SPRINGS ROAD 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Force Black, White, etc. 9 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: BLACK 3 🛣 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. I other than " condary (0-12) College (1-4 or 5+) 12TH GRADE FOOD SERVICE WORKER FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, MARGURITE MATILDA BOWMAN SPRIGGS GEORGE PHILIP SPRIGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 sl Health a JEROME FOSTER MONTGOMERY / SON P.O. BOX 364, INDIAN HEAD, MARYLAND 20640 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ST. CATHERINE'S CHURCH CEMNOVEMBER 30, 2012 MC CONCHIE, MARYLAND 4 Donation 5 Other (Specify) 21. Stimuture of Funeral Service biconsec THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ DRONARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown IDIOPATHIC THROMBOCYTOPENIC PURPURA Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? After this certificate 1 ☐ Yes 2 ☐ No Yes ours after death.

eral Director: After this certificatiled in by the funeral director. **Division of Vital** Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 24 hours Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Norse Proofficeer. To five best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and iranser as stated 2012 chae Name and address of perspn who completed cause of death (Item 23a) (Type, Print)

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Registrar
DHMH 17 Rev 06-2011

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Division of Vital Records, P.O. Box 68760

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		For State Registrar		iaryland	•	rtment of F ificate of L		Mental Hy	/giene Reg. No	2012	40179
Physicia	n/	Decedent's Name (First, Middle, MILDRED ELEANOR		тъти А	TT			2. Date of Do		12 Year	3. Time of Death 11:45A M
Medic Examin		4a. Facility Name (if not institution, g WILLIAM HILL MA	give street and number)	DENIIA	T.L.	4b. City, Town, or EAS	r Location of Dea		4c.	. County of Death	
Funeral Director				ge (In <i>yr</i> s. I <i>a</i> s	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min				place (State or Foreign
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Usual Residence of Decedent	т		Town or Loca	ation 10f. Zip Code			10- 0	tizen of What Cou	10d. Inside City Limits 1 🔀 Yes 2 🗆 No
rth with th	uneral	501 DUTCHMANS	LANE	Ever in II S	12 14	21601 as Decedent of H	ienanic Origin? (5	Specify Ves or No	US	Α	
urs after des tural", or ite	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🏋 Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 X  If Yes, Give  Year or Dates.	)	If 1	Yes, specify Cuba	n, Mexican, Puer Specify:	rto Rican, etc.)		14. Race - Americ Black, White, Specify: WHIT	etc.
within 72 ho giene. er than "nai , the Medica	<b>Completed</b>	15. Decedent (Specify only highes Elementary/Seconday (0-12) 12		5+)	(Give ki	ent's Usual Occup nd of work done o NOT use retired) IAKER	ation during most of wo	orking		ind of Business In	•
ld be filed Mental Hy larked oth atic event	To Be	17. Father's Name (First, Middle, La WILLIAM T. KELL				ame (First, Middle A WRIGHT		Surname)			
nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship THOMAS MENDENHA								Town, State, Zip ( MD 21663	
. Page 1 ar tment of H <b>tant: If iter</b> <b>jury or oth</b>		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		e ce	oLIVE	ition (Name of atory or other place CEMETER	RY 11/	Date 16/2012	ST.	ocation - City or To	S, MD
permit Depart Impor any in		21. Signature of Funeral Service Lic	ensee . MERC	ER	' '					FUNERAL MD 21601	HOME, P.A.
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or o shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each lir	STA	(GE -	The mode of dyin		ac or respiratory a	urrest,		Approximate Interval Between Onset and Death
ite be executed hysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as		·						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 🔲 Fetal at time of de	death 3	Ectopic pregnand Other (specify)	су			23d. Date of deliv Month	ery Day Year
uires that the signed by ald be detac		Part II. Other significant condition HYPLRYENSION									he cause of death? bably 4 💢 Unknown
The law req	Completed by							per	s an opsy formed? ; 2 🗷 No	prior to co death?	psy findings available impletion of cause of
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ding Phys h. After this funeral di	ate: To	27, Manner of Death  1 Natural 5 Pending	28a. Date of inj (Month, Da	ury :	ER/Outpatient 28b. Time of injury	3 ∐ DOA 28c. Injury	4 X Nursing y at	Home 5 ☐ Res 28d. Describe		Other (Specify y occurred	/)
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he Hospit in 24 hour he Funera	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of Nurse Practioner: To the	examination	and/or investi	gation, in my opinio	on, death occurred	d at the time, date	and place	e, and due to the ca	use(s) and manner stated
To the virth Control		29b. Signature and title of certifier	alle A	75AS,	ING Mi	29c. License	TZ0	94	11.	te signed (Month,	2
512		31. Date filed (Month, Day, Year)	ho completed cause of	death (Item	23a) (Type, Pr	int)	Mrs Al	se fede	egr:	sa ueb,	MD
Stat Registra		31. Date filed (Month, Day, Year)	2012 32. Regist	rar's Signatu	ire \$. 4	arke					

Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Algire Physician/ MCFaul NOVEMBER 12, 2012 1:30 A M Medical 4a. Facility Name (if not institution on, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WILLIAM HILL GARDENS TALBOT EASTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 220-03-8253 Director 1 X M 2 🗆 F 99 10/26/1913 MARYLAND Usual Residence of Decedent or 28a-f show 10a. State 10h County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits must be notified at MD TALBOT EASTON 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral "natural", or items 23a 545 CYNWOOD DRIVE 21601 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No If Yes, Give Black, White, etc ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify WHITE 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the 12 ATTORNEY/LAWYER LEGAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIAM NEAL MCFAUL MARY ELIZABETH CALTRIDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5093 JERICHO ROAD, COLUMBIA, MD BARBARA M. COOK, DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 11/14/2012 STEVENSVILLE, MD 21. Signa FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Aspiration disease or condition resulting in death) Medical Examiner Late Stare Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) As : > After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Secrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 2077623 11-12-12 Thurst 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 545 Cynwood Dr

State Registrar

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31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26, Physician/ Month Floyd Clarence MYERS, Jr. November 2012 21:20 p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner 364 Antietam Drive Hagerstown Washington If Under Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Feb. 15, Months Hours 1 X M 2 D F Min. 216-14-6319 Yrs 88 Director Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Hagerstown 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? ö "natural", or items 23a o Funeral 21742 USA 364 Antietam Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc by 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1957–64 white 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) aircraft factory inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Floyd Clarence Myers, Sr. Grace Irene Barton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21134 Twin Springs Dr., Chewsville, Maryland 21721 Deborah Warrenfeltz - daughter t If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) permit. Page Department o Important: If any injury or or Cedar Lawn Mem.Park |11/30/12 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland . Signature of Funeral Service Licer 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Due the (a as a consequence of): Physician/ disease or condition Medical resulting in death) Examiner Langa Sequentially list conditions, if any leading to impose cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 be detached for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Abdenial aschi 24a, Was an has autopsy perform page 2 Uhnen Edosmunie After this certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 \(\text{\subset}\) Nursing Home 5 \(\text{Residence}\) Residence 6 \(\text{\subset}\) Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: Al ... Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

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29b. Signature and title of certifie

31. Date filed (Month, Day,

teran 32. Registrar's Signature



Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DUOS 7600

MP 21783

29d, Date signed (Month, Day, Year)

27

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29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Evelyn Pauline Maddox Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown Meritus Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Nov. 27, 1916 Maryland 215-28-3496 96 **Director** 1 □ M 2X F Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1 Yes 2 No Williamsport Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be Funeral USA 9112 Downsville Pike 21795 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc þ 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. White 3 ♥ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Home 9 Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen E. Hoxter Ullman Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra 9112 Downsville Pike Williamsport, Maryland 21795 Janice Schultz-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛚 Burial 2 Cremation Cedar Hill Cemetery Nov.30,2012 Baltimore, Maryland 4 Denatio 5 Other (Spe 22. Name and Address of Facility Osborne Funeral Home, P.A. Sign ture of uneral Sen 425 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician RONARY ARTERY disease or condition resulting in death) C Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Physician/Medical Examiner cause. Enter Underlying Day to for as a consequence of PALLURE as the burial-transit A CUIE RENA Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury and that initiated events Due to (or as a consequence of) resulting in death) Last nding physician P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?
1 Yes 2 A No Month Day Year Pregnant at time of death 9 Ulnknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t d be det þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2: autopsy performe 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 N 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Hospital ၉ 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral of 27. Manner Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 Yes of Funeral Director; All bletely filled in by the fu Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AZIN MOHAMMA

Registrar

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 2 0   2   4 0   8 3											
	_		Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death								
н	Physicia Medic		Edwin C. Muhly, Jr.	November 17, 2012 11:35 PM								
7	Examin		4a. Facility Name (if not institution, give street and number)  205 Mill Harbor Drive	4b. City, Town, or Location of Death Arnold  4c. County of Death Anne Arundel								
100	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Gountry Gountry Gountry Gountry Gountry Gountry								
	Director		213–28–7655 1 M 2 □ F 82 Yrs.	June 17,1930 Maryland								
	and show	tor	10a. State 10b. County 10c. City, Town or L	ocation 10d. Inside City Limits								
	Mary 28a-f otifie	irec	MD Anne Arundel Arnold	1 Tes 2 X No								
	ith the 23a or st be n	Funeral Director	10e. Street and Number  205 Mill Harbor Drive	10f. Zip Code 10g. Citizen of What Country? USA								
	ems 2	nne		Was Decedent of Hispanic Origin? (Specify Yes or No-								
21215-0036	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at	Completed by F	1 ☐ Never Married 2 ☒ Married 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2☒ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.  Specify: White								
15-(	72 hot "nat edica	ple	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working  16b. Kind of Business/Industry								
712	vithin iene.	Con	Elementary/Secondary (U-12) College (1-4 or 5+)	Baker Bakery								
-	be filed v ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, Last)  Edwin C. Muhly, Sr.	18. Mother's Name (First, Middle, Maiden Surname)  Irma Rupprecht								
Maryland	of Health and Mental F of Health and Mental F fitem 27 is marked of r other traumatic ever	î	19a. Informant's Name/Relationship (Type, Print)  Kathleen Muhly / Wife 19b. Mai	ing Address (Street and Number or Rural Royte Number City or Town, State, Zio Code) MILL Harbor Drive Arnold, MD 21012								
Baltimore,	Page 1 and lent of Hea nt: If item ry or othe			nosition (Name of matter) November 26, Baltimore, MD								
Baltii	permit. Page 1 a Department of I Important: If ite any injury or ot	9	21. Signature of Funoral Service Licensee	arranco & Sons, P.A. Severna Park Funeral Home 95 Ritchie Hwy, Severna Park, MD 21146								
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, for heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arrest,  Approximate								
	hysician/	. (12		Interval Between Onset and Death								
1	Medical Examiner		resulting in death)  Due to (or as a consequence of):	- non alcohol								
	3.5%	ıer	Sequentially list conditions,  Due to lurge a consequence up.	- non alcohol								
	d d ansit	Examine	Thany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Complete  Due to (or as a consequence of):	Heart Block								
	ate be executed hysician and the burial-transit	E	resulting in death) Last  Due to (or as a consequence of):									
09,	ate be ohysic the bu	dical	d									
<b>687</b>	ertifica Iding p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	22d Pate of delivery								
Box	eath c atten d for u	iciar	in the past 12 months?  1 Live Birth 2 Fetal death 3 1 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)								
О.	the d by the tacher	hys	g □ Unknown									
ls, P.O.	the Hospital or Attending Physician: The law requires that the death certificate be executed that 4 hours after death.  The Luneral Director, there this certificate has been signed by the attending physician and the Funeral Director, the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied in the funeral director.	by	Part II. Other significant conditions contributing to death but not resulting in the Diabetes mellitus, Perip	heral neuropuths 1 yes 2 to 3 probably 4 Unknown								
of Vital Records,	w requ	Completed	Aortic valve disease, At-	24a. Was an autopsy findings available prior to completion of cause of								
Rec	ysician: The law is certificate has director, page 2	Som	Cerebrovasculur disease	autopsy prior to completion of cause of death?  1 □ Yes 2 ☑ No								
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
of ∨	Phys r this c eral dir	<u>د</u>	1 Yes 2 Ano 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of	ent 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)								
o uc	nding ath. r; After re fune	icate	1 Matural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 □ Yes 2 □ No								
Division	or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Ω	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director, After this completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner; On the basis of examination and/or inve	occurred at the time, date and place, and due to the cause(s) and manner as stated.  stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	the lithin 2 the long	Me		e, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)								
	No CO		Millian MI	0 43303 11-19-2012								
11			30. Name and address of person who completed cause of death (Item 23a) (Type,									
狀	5		8628 Kutchie Hwy, Suite 108	rasadena, IND XII22								
	Stat Registra	e ar	31. Date filed (Month, Day, Year)  NOV 2 0 2012  32. Registrar's Signature	all all								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton 1637 Eton Way 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **Director** <u>577-60-9</u>451 1 X M 2 🗆 F 81 Yrs. 10/03/1931 Greece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Crofton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1637 Eton Way 21114 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 🗶 Married <u>6</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Physician Medical æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Pericles Nicholas Moutsos Sousanna Gikouria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $1637\ Eton\ Way$  , Crofton, Maryland 21114Cleopatra N. Moutsos/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Demetrios Greek Cem. 11/26/2012 Annapolis, Maryland <sup>22. Name and Address of Facility</sup> George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 21. Signature of Faneral Service Licensee Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final END-Stage Dementia Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy 1 Yes 2 No ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending ours after death.

leral Director: Aft
filled in by the fu work? 1 ∐ Yes 2 ∐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Ms Rajapahum D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD S 203 NS Rajapakse MD 2835 Smith N

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

26

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day Month Ye ar **Physician** 0912M 2012 November 21 Edwin Mentecki, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Easton Talbot Memorial Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) 2/3/1944 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Hours Months Days 1 XM 2□ F Maryland 68 Director 217-40-7608 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be profiled at 1 Yes 2 No Director Caroline Ridgely Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21660 or items 23a 12695 Eveland Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2♠ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 🛣No Specify: If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Municipal Police Dept. 12 Policeman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Crumbliss permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev Marjorie Mentecki, Sr. Edwin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12695 Eveland Rd. Ridgely, MD\_21660 Sandra Mentecki/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemeterv 11/28/12 21. Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. Denton, MD 12 South 2nd Street 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cute Cerebro Vascular Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Delerium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Chronic Kidney Dicease burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ COPD 1 Tyes 2 No 3 Probably 4 M Unknown Completed Obstouctive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 □ No HUPER tension 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 
☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Mohan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S D D S

219

32. Registrar's Signature

Constant of the second

29c. License number

10069567

Nov, 23,

Washington St Easton, Md 21601

ames Logan McI	1	nald I- For State Registrar	State of Mary		epartment c Certificate c		and Mer	ntal Hyg		2 () eg. No.	12	4018
Physician Medical Examin	n/	<ol> <li>Decedent's Name (First, M</li> </ol>		7					Date of Deat Month	Day Year		Time of Death 1728 hrs
Medical Examin		James Loga: 4a. Facility Name (if not instit	n McDonale tution, give street and		-	4b. City, Towr	n, or Location		November	4c. County of	Death	1720 1113
		16828 Centerfield	Way			Olney				Montgom	ery	
Funeral Director		5. Social Security Number 265–90–5762	12 141 2 1		yrs. last birthday) 56 <sub>Yr</sub>		Year If Und Days Hour		8. Date of Birt 03/12,	h(MM/DD/YYYY) /1956	Foreign	ry) Ohio
ku e		Usual Residence of Deceder 10a. State 10b. Cou		10c.	City, Town or Loca	ation					10	Od. Inside City Limits
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Maryland 28a-f shnw d at once.	Director	10e. Street and Number			-	10f. Zip Co			10	0g. Citizen of Wha		
th the Maryland 23a or 28a-f shu nntified at once.		16828 Cente:					20832			Unite		
er death wi	by Fune		Married Armed  1 X Yes  Divorced If Yes, Give Y	ear $19\overline{88}$	No −1999 1	/as Decedent of Yes, specify Co	uban, Mexica	in, Puerto R y:	ican, etc.)	14. Race - White, Specify:	etc. Wh	n Indian, Black, ite
72 hou n "nat	etec	Elementary/Secondary (0-		(1-4 or 5+)	during r	most of working						,
15-0036 filed within 72 hours aft Hygiene. aft after than "maturnal" the Medical Examine	Completed	12	6		Mar	power	A			U. S.	Gove	rnment
21215-0036 Nuld be filed within 7 Mental Hygiene Hagiene tean	မ်ို မြ	17. Father's Name (First, Mic Andrew Well:		onald				er's Name (f ırtha	First, Middle, N Reed	Maiden Surname)		
2121 hould be fill and Mental F is marked		19a. Informant's Name/Relat	ionship (Type, Print )		19b. Mailir	ng Address (8	Street and Nu	Imber or Ru	ral Route Num	nber, City or Town	, State, Z	ip Code)
e, MD to and 2 show Health and item 27 is traumatic	ŀ	Thomas P. Po	Ollatz/Faii		20b. Place of Dispo				v Olne	y, Maryl		
imor Pages   ment of   tant: If		1 Burial 2 Crema 4 Dopation 5 Othe 21. Signature of Funeral Sen	Specify:	from State	crematory or o	ther place)	em.	11/2	8/12	Alexan	dria	, Virginia
Balti permit. Departu Imports		(1015.10	unto		P.	O. Box	5038,	La	ytonsv:	arber Fu ille, MD	2	0882
Physician /Medical		23a. Part I. Enter the disease railure. List only one ca	ause on each line			_	-	cardiac or r	espiratory arre	est, shock, or hear		Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final dise or condition resulting in deat			osclerotic Caro	diovascular	Disease		'			Deali
led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initiate events resulting in death). La	ed <sup>c.</sup> ast Due to (or as									
D,  be executed sician and ourial - transi	edical	UNPENDED	dAMENDE	)								
	ΣI	IF FEMALE: 23b. Was decedent pregnant past 12 months?  1 Yes 2 No 9	in the 1 Live 4 Pre	s, outcome of birth gnant at time	2 F	etal death Other (Specify)	3 Ectop	pic pregnanc	cy	23d. Date of d Month	delivery Day	Year
P.O. res that the signed by the detache	E E	Part II. Other significant co		to death but	not resulting in the	underlying cau	ise given in F	Part I.		bacco use contrib		cause of death?
Division of Vital Records, P.( ral ar Attendug Physician: The law requires than rs after death. al Directur: After this certificate has been signed led in by the funeral director, page 2 should be deter	Completed	Chronic Alcoholisr	-						24a. Was a	an 24b. W sy pr med? de	ere autop	osy findings available apletion of cause of
tal Rec	ပ္ Be	25. Was case referred to me				26.F	lace of Death	h (Check on				
F Vit	ᇰ	examiner?  1 ✓ Yes 2 No	Hospital: 1		2 ER/Outpatier		Other 4			Residence 6		cene
on of oding Photon in the funeral		27. Manner of Death  1 ✓ Natural 5 □ F	28a. Da (Moi Pending	te of Injury hth, Day,Year)	26b. Time of		Injury at Wo		8d. Describe h	now injury occurre	d	
Divisior Haspital ar Attead 24 hours after death [Funeral Director: stely filled in by the	Certification:	2 Accident I 3 Suicide 6 (	Investigation		- At home, farm, str				8f. Location (S or Town, S		r or Rural	Route Number, City
Divi	Medical C	one) 2 Medical	ng Physician: To the b Examiner:On the basi and manne	s of examina	-							ause(s)
Jy N	Ž	296 Signature and title of ce	rleis	dse of death	(Item 23a)		.C.M.E.	er		29d. Date signe November 2		
\( \rangle \( \rangle \)		Laron Locke MD.	Assistant Medic			Baltimore St	reet, Balti	more, MI	D 21223			
Sta Registr	-	31. Date filed (Month, Day, Ye	2012	Registrar's Si	gnature parks	1						
DHMH 17 Rev 1/200		<b>5 5 6 7</b>	OCME		ORIGINA	AL						

		-	For State	State of Ma	aryland		rtment of H ificate of D			iene <sub>eg. No.</sub> 20	12	40187
			Registrar     Decedent's Name (First, Middle, La	ast)					2. Date of Deat	h	_Year	3. Time of Death
	Physicia Medic	al .	NANCY SUE NASH				4b. City, Town, or	Leasting of Dooth	NOVEMBE	R 19 20	1 <sup>Vear</sup>	4:32 P M
	Examin	er	4a. Facility Name (if not institution, giv ANNE ARUNDEL ME		ER		ANNAPO			ANNE		DEL
	Funeral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign try)
	Director		213-58-0327 Usual Residence of Decedent	1 □ M 2 🛣 F	63	Yrs.			11/15/1	949	MARYLAND	
	/land f show	tor	10a. State 10b. County			Town or Loc					1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	r 28a- notifie	Director	MD QUEEN A	ANNE'S	GR/	ASONVI	10f. Zip Code			10g. Citizen of	What Coun	
	with th	Funeral	700 LONG POINT	ROAD			21638			UNITED		1
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7121	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at											
nd	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surnal SUZANNE DUNCAN  18. Mother's Name (First, Middle, Maiden Surnal SUZANNE DUNCAN										e)	
ryla	JOHN BROOKE DUVALL, JR  SUZANNE DUNCAN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St											Code)
Ma	JOHN BROOKE DUVALL, JR  19a. Informant's Name/Relationship (Type, Print)  JOHN B. DUVALL, III / BROTHER  20b. Place of Disposition (Name of 20b. Place of Disposition (Name of 20c. Location - Company)  20c. Location - Company of other place.											
ore,	20a. Method of Disposition  20a. Method of Disposition  20b. Place of Disposition (Name of CHESAPEAKE CREMATION 11/21/2012 STEVENS)										,	
Baltimore, Maryland 21215-0036	1   Burial 2 \(\text{Donation 3   Removal from State}\) 4   Donation 5   Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL LOGS SHAMPOCK ROAD CHESTER MD 216											
Ba	permit. Departr Importa any inju		21. Signature of Fulleral Service Lice	D		FE	LLOWS, H 6 SHAMRO	ELFENBEIN CK ROAD.	WALL WENT WAR CHESTER	AM FUNE MD 21	RAL 1	HOME, P.A.
f	nysician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	e. -DSL		r the mode of dyin	g, such as cardiac	or respiratory arm	est,		Approximate Interval Between Onset and Death
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	ate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):					_	
09	e be e) lysiciar le burià	dical		d								
687	eath certifical attending ph I for use as th	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. D	ate of deliv	very
. Box 687	he death c y the atten sched for u	Physician/Me	in the past 12 months?  1 ☐ Yes 2 X No 9 ☐ Unknown	1  Live Birth 4  Pregnant			Dectopic pregnand Other (specify)	;y		м	onth	Day Year
ls, P.O.	requires that the dea been signed by the a should be detached f		Part II. Other significant conditions	contributing to death	but not resul	Iting in the u	inderlying cause gi	ven in Part I.	23e. Did to	/ _		the cause of death?
Records,	≥ ∞ ⊲	Completed by							24a. Was autor perfo 1  Yes	nsy rmed?	prior to co death?	opsy findings available ompletion of cause of
ital	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			12	ace of Death (Chec		s $\Box$ ov	har (Canoit	5.1
of V	g Phys er this neral di	e: 1	27. Manner of Death	28a. Date of inj (Month, Da	ury 2	ER/Outpatier 28b. Time of injury	nt 3 DOA Oth	v at	ome 5 Residence 128d. Describe h			y)
uo	tendin leath. tor: Aft the fur	ifica	1/☐Natural 5 ☐ Pending 2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could no	tion			M 1 □	Yes 2 ☐ No	206 1	Name of the second State o	har as Dum	al Route Number,
Division of Vital	or At after o Direct in by	Ser	4 Homicide determine	ed 28e. Place of In building, e	jury - At non tc. <i>(Specify)</i>	ne, tarm, str	eet, factory, office		City or Tow	in, State)	ber or nura	ar noute Namber,
	To the Hospital or Attenting Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certificate:	Chock 2 Medical Eva	hysician: To the best of aminer: On the basis of	examination	and/or inves	tigation in my opini	on, death occurred	at the time, date a	ınd place, and d	ue to the ca	ause(s) and manner stated.
	o the hithin 2.	Me	only one) 3 Certifying N 29b. Signature and title of Confifer	lurse Practitioner: To t	he best of m	y knowledge	, death occurred at 29c. Licens	the time, date and p	lace, and due to t	he cause(s) and 29d. Date sign	manner as	stated.
			1/11/	MD			24	5185		11/1	9/11	2
	30		Aldre 1	no completed cause of		ton	e H	ecycay Pring	Anna	polis, A	D 3	1401
	Sta Registi		31. Date filed (Month, Day, Year) NOV 2 0	2012 32. Regist	trar's Signatu	ure 6. 19	back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November ĬĞ, 2012 George Nesbitt 10:05 PM 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Heartland Healthcare Center Montgomery Adelphi Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Months (Month, Day, Year) Hours Min, 577-50-0727 1 X M 2 □ F Usual Residence of Decedent May 3, 1938 Virginia 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5721 Falkland Place 20743 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Black 1 Yes 2 No Yes, Give 3 Widowed 4XXDivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) years Department of Public Works Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dock Nesbitt Minnie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zachary B. Nesbitt Sr. Son 13804 New Acadia Lane Upper Marlboro, Md. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park Nov 23, 2012 4 Donation 5 Other (Specify) Landover, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Euneral Service Licenses M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Pmysician/ Medical Examiner

State

Physician/

Medical

Examiner

**Funeral** 

**Director** 

ms 23a or 28a-f show must be notified at

or items

"natural",

2 should be filed within 72 In and Mental Hygiene.
7 is marked other than "r

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

Examiner

event, the Medical

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Completed

Be

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

requires that the death certificate be

by Physician/Medical Examiner ig physician and as the burial-transit use ģ Be Completed 2

funeral director, Certificate:

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law

2 51

State Registrar

Medical

29b. Signature and title of certification

Chandra Korapati, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

shock, or heart failure. List only o	ne cause on each line.		Interval Between
Immediate Cause (Final disease or condition	Conrestive Heart Failure		Onset and Death
resulting in death)	a. Due to (or as a consequence of):		
	Uremia		
Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):		
Cause (Disease or injury			
that initiated events resulting in death) Last	c. Acute Respiratory Failure  Due to (or as a consequence of):		
la contract of the contract of	,		
	d. Cardiac Arrhythmia		
IF FEMALE:			-
200. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery
in the past 12 months? 1  Yes 2 No	4 Pregnant at time of death 5 Other (specify)		Month Day Year
g 🗆 Unknown	9 Unknown		
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Anemia		1 ☐ Yes	2 ☐ No 3 ☐ Probably 4 💆 Unknown
Malnutrition_		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
		performed?	death? No. 1 ☐ Yes 2 ☐ No.
25. Was case referred to medical	26. Place of Death (Check		100 2010
examiner? 1 ☐ Yes 2 🏋 No	Hospital: Other:		0 T 011 - 10 - 111
27. Manner of Death		me 5 Residence 28d. Describe how inju	
1 Natural 5 Pending	(Month, Day, Year) injury work?	tod. Describe now inju	dry occurred
2 Accident Investigation 3 Suicide 6 Could not be			
4  Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, le)
		,,	
29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the cause(s)	and manner as stated.
only one) 3 Certifying Nurs	ner: On the basis of examination and/or investigation, in my opinion, death occurred at e Practitioner: To the best of my knowledge, death occurred at the time, date and pla	trie time, date and place, ce, and due to the cau:	ce, and due to the cause(s) and manner stated se(s) and manner as stated.

29c. License number

D0054855

Suite B

29d. Date signed (Month, Day, Year)

Greenbelt, Md.

November 26, 2012

20770

DHMH 17 Rev 06-2011

207 Hanover Parkway

Registrar's Signature

Margaret Catherin		Patton 1- For State	Sta	ate of Mar			tment of		nd Men	ital Hy		deg. No.	201	2 4018
Physicia Medical Examin	n/	1. Decedent's Name		THERINE							2. Date of Dea Month Novembe	ath	Year 2	3. Time of Death 1902 hrs
		4a. Facility Name (if Calvert Men			number)			b. City, Town, Prince Fre		of Death		Calv		1
Funeral Director	- 1	5. Social Security N 215-36-43		6. Sex			t birthday) Yrs.	If Under 1 Ye Months Da	ear If Und	er 24Hrs. s Min.	8. Date of Bi 11/26	rth(MM/DD/ 0/1941	Enroi	rthplace (State or gn puntry) MD
ow any			10b. County	E GEORGI			own or Locati							10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	MD 10e. Street and Nur 2130 ALI	mber			<u> </u>	AUN HI.	10f. Zip Code	745		1		of What Cou	·
or items	Funeral	11. Marital Status	ed 2 Ma	12. Was a Armer 1 Yearced If Yes, Give	Decedent Eve d Forces? s 2 <b>X</b>		If Y	s Decedent of Hes, specify Cub	Hispanic Dri an, Mexicai	n, Puerto F	cify Yes or No	0- 14.		rican Indian, Black,
The state of the s						eted)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired)  DRIVER/OFFICE WORKER  16b. Kind of Busines PRINCE GE COUNTY G						NCE GEO	
D 21215-0036 should be filed within and Mental Hygiene. 7 is marked other than attic event, the Medic	Be	17. Father's Name (	URTIS						RO	SIE A	First, Middle,	OUNG	CURTIS	
MD 21 md 2 should salth and Mer em 27 is mar	<u>۵</u>	19a. Informant's Na GWENDOLY  20a. Method of Disp	N PATT		ITER	20h. Pi	3354	Address (Str CURTIS	DRIVE	, #10		TLAND	, MD 2	
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other trauman		1 X Burial 2	Cremation Other Sp	ecify:	al from State	cr	ematory or oth	er place) LES CEM	ETERY	1				MARYLAND
Balt Balt Depart Import Import		LYDIA C. THE 23a. Part I. Enter th	JANIUN J	CHINSON M		death. I	343	KNIUN FU 9 LIVING 1e mode of dyin	STON RO	AD. TI	VIDTAN HE	AD MAR	YLAND 2 or heart	Approximate Interval
/Medical Examiner		failure. List on Immediate Cause ( or condition resulting	- Final disease	a. Atheroso	clerotic Ca			ease						Between Driset and Death
	Examiner	Sequentially list con if any, leading to im cause. Enter Unde (Disease or injury to	mediate rlying Cause hat initiated	C	as a conseque	ĺ								
execut an and al - tra	dical Ex	events resulting in UNPENDED	deam) Last	dAMENDE					<del></del>			<del></del>	·	
K 68760 recrificate bending physical	Physician/Med	IF FEMALE: 23b. Was decedent past 12 months  1 Yes 2 V	?	e 1 Li	es, outcome over birth egnant at time		2 Fe	tal death S	3 Ectop	ic pregnan	су		ate of deliver	y Day Year
P.O. Bcs that the desgned by the a	by Phys	Part II. Other signi		9_0	nknown ng to death bu	ut not res	sulting in the t	nderlying caus	e given in P	Part I.		-		the cause of death?
of Vital Records, P.O. Boxing Physician: The law requires that the death After this certificate has been signed by the att uneral director, page 2 should be detached for	Completed									_			prior to death?	utopsy findings available completion of cause of
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n of Vital ding Physician: h. : After this certi	on: To	1 Yes  27. Manner of Deat  1 Natural	No h	28a. D	ate of Injury onth, Dey, Year)		ER/Outpatient 28b. Time of I	njury 28c. tr	njury at Wor	k? 2	Home 5	Residence how injury of		er.
Division of Vital Is the Hospital or Attending Physician: hin 24 hours after death.  The Funeral Director: After this certiful protector is the funeral director.	Certification:	2 Accident 3 Suicide 4 Homicide	Inves	tigation		/ - At hor	me, farm, stree	et, factory, office			28f. Location or Town,		Number or R	ural Route Number, City
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical Ce	29a. Certifier	Certifying Pl Medical Exa	nysician: To the miner:On the ba and mann	sis of examin	nowledge ation an	e, death occur d/or investiga	red at the time, ion, in my opini	date and p	lace, and o	due to the cau	use(s) and m e and place,	anner as sta and due to t	ted. he cause(s)
• Frank Gran	Me	29b. Signature and	title of certifie		2		-,-		nse numbe C.M.E.	r			esigned (Mender 24, 2	onth, Day, Year)
80-5		30. Name and addr Jack Titus N	4D Don	who completed outy Chief Me				Baltimore S	treet, Ba	ltimore,	MD 21223	3		
Sta Regist	ate rar	31. Date filed (Mon.	NOV 2	<b>7 2012</b> 32	Registrar's	Signatur	B. 40	uld			_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Florence Chambers Phillips 12:55 p™ 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil 154 Blythedale Road Perryville 5. Social Security Number 8. Date of Birth (Month, Day, March 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Year 934 78 Pennsylvania 456-48-8090 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Perryville 28a-f 1 X Yes 2 No Maryland Cecil 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21903 U.S.A. 618 Cecil Avenue items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 0 ρ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify. should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", Specify: White Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation V.A. Medical Center (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Perry Point, Maryland Agent Cashier Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Zell Ernest Chambers 1 and 2 should bot Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 Orchard Drive, Port Deposit, Maryland (daughter) Teresa Ryan Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West Chester, permit. Page 1 a
Department of H
Important: If ite Page 1 injury or 1 Burial 2 X Cremation 3 Removal from State R.A.Ferris & Co., Inc: 11/26/12 4 Donation 5 Other (Specify) <u>Pennsylvania</u> 21. Signature of Funeral Service Licenses Leemand Apartic Fritton & Son Funeral Home, P.A. any Ihomas m 50 Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Kulmonary Disease Physician/ disease or condition resulting in death) Unknown Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (of as a consequence of, Exami sician and burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last inding physician ause as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur page 2. P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No dauchter's residence Be 26. Place of Death (Check only one) Hospital Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 ntering Other (Specify, 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work?
1 Yes 2 No 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tit of certifier 29d. Date signed (Month, Day, Year) 11.26.2012 Doug3322 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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State Registrar 31. Date filed (Month, Day, Year)

NOV

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32. Registrar's Signature

Eleton MD21921.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 23 2012 7:55P M Edward Neal Porter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick Frederick Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) Director 215-76-7214 1**X** M 2 □ F 53 Jan. 1,1959 Washington D.C. ir than "natural", or itams 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location daath with the Maryland 10d. Inside City Limits Director Maryland Frederick New Market 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6702 Green Valley Road 21774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2Å☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry Ja filed with: Fal Hygiena. Ser than "F (Specify only highest grade completed) during most of working U.S. Postal Service Elementary/Secondary (0-12) College (1-4 or 5+) Letter Carrier should ba filed with and Mental Hygien Is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Α. Porter Shirlie Hood traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Page 1 and 2 sh Department of Haalth ar Important: If item 27 is any injury or other trau Megan A. Porter - Daughter 6702 Green Valley Rd., New Market, Maryland 21774 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Metropolitan Crematorium 11/29/12 Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 21. Signature of Forteral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Acute Hypercarbic Respiratory Failure Physician/ Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.

To the Funarai Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Acute Asthama Excaberation that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ည 1 Manatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) M-D. 11/23/2012 MDD69963 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thakallapali 400 7th St Frederick, Md 21701 W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Geneva Doris Pickett Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Rehabilitation LaPlata Charles If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Min. Hours Director 238 80 4913 1 □ M 2 🗶 F 68 Dec 22, 1943 North Carolina Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Clinton Maryland Prince George's 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 5949 East Boniwood Turn 20735 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Never Married 2 Married Yes 2 X No þ If Yes, Give 1 Yes 2 No Specify: Specify: Black 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Admin Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည Alton James Pickett Exie L. Farrior 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Pickett (sister) 5949 East Boniwood Turn, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Nov 24, 2012 Chinquapin, North Carolina Pickett Family Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest of heart failure. List only one cause on each line. 23a. Part 1. E shock, 9 Interval Between Immediate Cause (Pinal Onset and Death disease or condition resulting in death) Due to (or as a consequence of):
ATION (1601)050Y

Physician/ Medical **Examiner** 

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certificate I

After this

Funeral Director: A

within 2

Hospital or Attending 24 hours after death.

by

Completed

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Certificate:

Medical

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Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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should be filed with and Mental Hygien 7 is marked other th

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last physician Physician/Medical

Due to (or as a consequence of

orterial disease peripheral

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No g Unknown

29b. Signature and title of certifier

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Pregnant at time of death g Unknown

Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy
5 Other (specify)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy

2 No 3 Probably 4 Unknown 24b Were autopsy findin

Yes

. 75.	prior to completion of cause
	death?
	1 Yes 2 No

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2**X**No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?

1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be determined

2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

> 29d Date signed (Month, Day, Year) 20

29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

D070900 KALL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glan Burnie, MD

Registrar

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended 1 - State Registrar #9, tchd, 11/13/12, r1s Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ ILLI A M Mercer 2012 Hnne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner he Memorial Hospital albot Easton Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) PA 8. Date of Birth **Funeral** 13-24-25 Months Hours (Month, Day, Year) Director 1 🗆 M 2 🗶 F 83 06-06-1929 Usual Residence of Decedent other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Aside City Limits Director 1 X Yes 2 ☐ No 10g. Citizen of What Country? Funeral USA 21617 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) eacher's 12 Education Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Beatrice unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sho Department of Heatth an Important: If item 27 Is any injury or other trau Centreville, ma. 2/617 Holton Karen Maddox -daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Field Cem. 11-16-2012 Centreville, Md. 22. Name and Address of Facility Bennie Smith Funeral Home 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final Sepsic Physician/ disease or condition Medical resulting in death) Examiner ailure enal Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events bdomyo Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and inpletely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complete only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI Mohan NON 0006956 08 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ashington Street 32. Registrar's Signature State

Registrar

			For State Registrar	State of Ma	aryland / l		artment of F tificate of L		na IVI	ental Hy	giene Reg. No	71117	2	40194
		,	Decedent's Name (First, Middle, Language)	ast)						2. Date of De	ath			3. Time of Death
	Physicia Medic		Jason Cole Po	tts						Novem5	er 7	201	2	1129 AM
	Examin		4a. Facility Name (if not institution, give				4b. City, Town, or				4c.	. County of De		agt on
gar <sup>it</sup>	1000		Meritus Medical  5. Social Security Number 6.		e (In yrs. last birt	hdav)	If Under 1 Year	gersto		8. Date of Bir	th			ngton ace (State or Foreign
	Funeral Director			MX M 2 □ F		Yrs.	Months Days	Hours	Min.	(Month, Da	ay, Year)	C	ountry	1)
	*		Usual Residence of Decedent		35		<u> </u>			June 7	,197	/ N	_	yland
yland	-fsho edat	[호	10a. State 10b. County		10c. City, Town								100	d. Inside City Limits  1  Yes 2 X No
e Mai	r 28a notifi	Dire.	Maryland   Washin	gton		Wi]	lliamspor	t			10a Cit	tizen of What 0	Countr	
vith th	23a o st be	a	15227 Clear Spr	ing Road				.795			rog. On		JSA	, .
eath v	tems er mu	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba		n? (Spec	cify Yes or No-		14. Race - An		
So uffer d	", or i	ρ	1 XNever Married 2 Married	Armed Forces?  1  Yes 2 X  1f Yes, Give	No	1	Yes 2 X No		ruesto r	ilcail, etc./		Black, Wh Specify:		
Z1Z15-UU30 within 72 hours after death with the Maryland	atural sal Ex	Completed	3 Widowed 4 Divorced  15. Decedent's	Year or Dates.	162	Deced	lent's Usual Occup	ation			16b K	(ind of Busines	-	ite
<b>ن 13</b>	an "ng Medic	mpl	(Specify only highest of Elementary/Secondary (0-12)			(Give I	kind of work done of NOT use retired)	during most d	of workin	g	160. K	and or busines	5/11/00	stry
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should be	d Mental marked matic ev	-	Charles Keefer					Char.			Mye		7. 0	
Mary 2 should	Ith and 27 is m traum		19a. Informant's Name/Relationship  Charles K. Pott				g Address (Street							land 21795
re, M	<u> </u>		20a. Method of Disposition		20b. Place o	f Dispo	sition (Name of	-		ate		ocation - City		
Page			1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			*	matory or other place  Mem. Par	· i	ov. 2	9,2012	Wili	liamspo	ort	,Maryland
<b>Baltimore,</b> permit. Page 1 and	Department of Important: If any injury or once,		21. Signature of Funeral Service	nse	DI CCIII		. Name and Addre							
<b>n</b> 8,			() M Z ()	<i>u</i>			25 S. Cor					amsport		
			23a Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause on each line	the death. Do r	not ente	er the mode of dyin	ig, such as c	ardiac oi	respiratory a	rrest,			Approximate Interval Between Onset and Death
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	caminer		Commence Color CIPCHI ST Color Color	Due to (or as a	a co equence	El	epectio	us						
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de be executed	sian ar urial-t	al E	resulting in death) Last	Due to (or as/	consequence	of):	, ,							
ate b	physician and s the burial-transit	edical		d										
certific	certificate has been signed by the attending I rrector, page 2 should be detached for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of	deliven	v
<b>BOX</b>	d for t	Physician/M	in the past 12 months?	4 🔲 Pregnant a			Ectopic pregnand Other (specify) _	cy				Month		Day Year
at the d	by the tache	hys	9 🗌 Unknown	9 Unknown										
<b>7.</b> ₹	gned be de	by	Part II. Other significant conditions	contributing to death b	ut not resulting	in the u	inderlying cause gi	ven in Part I.						cause of death?
rds	een si	Completed										-		
Kecords, The law requires	has b je 2 s	mpl								24a. Was auto perf		prior t death	o com	sy findings available pletion of cause of
<b>7</b> 4	ficate or, pag		25. Was case referred to medical	E			26 P	lace of Death	Check	1 Tyes	2 (1) N	o 1 🗆 Y	es 2	P □ No
Vital ysician:	s certi	To Be	examiner? 1  Yes 2 No	Hospital:	ent 2 ER/O	ıtpatier	Oth	er.			idence 6	6 ☐ Other (Sp	ecifv)	
OT Ig Phy	ter this		27. Manner of Death  1 ☑ Natural 5 ☑ Pending	28a. Date of injur (Month, Day	ry 28b.	Time of injury		y at		8d. Describe				
endir	eath. or: Af the fu	ifica	2 Accident Investigat 3 Suicide 6 Could not	ion			M 1 □	Yes 2 🗆 !						
DIVISION OF tal or Attending Pl	offer differ dif	Certificate:	4 Homicide determine			arm, str	eet, factory, office		1	28f. Location ( City or To		nd Number or F e)	Ru <i>ral F</i>	loute Number,
pital C	ours a		29a. Certifier 1 Certifying Pl	hysician: To the best of	mv knowledge.	death o	occurred at the tim	e, date and p	olace, an	d due to the o	ause(s) a	and manner as	stated	d.
DIVISION OF VITAI To the Hospital or Attending Physician:	within 24 hours after death.  Jg the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check 2 Medical Exa	miner: On the basis of ex urse Practitioner: To the	xamination and/o	or invest	tigation, in my opini	on, death occ	curred at	the time, date	and place	e, and due to th	e caus	se(s) and manner stated.
10 ₩	i ‡ iii		29b. Signature and title of certifier	1. 12.1	10		29c. Licens	e number	10	,	29d. Da	ate signed (Mo	nth, Da	ay, Year)
	XX		> Buce E.h	'ewell /	11		Dé	726	10		11	12-11	12	<u> </u>
	4		30. Name and address of person who	o completed cause of d	eath (Item 23a)	(Type, F	rint) Nemoru	00 0	21 -	1 4	1000	5+nr	n	MD 21740
	Sta	te.	31. Date filed (Month Day Year)	32. Megistro	ar's Signature	1 - 1	TEMOI U	1	2100	110	2	0100		1-40 01 170
	Registr		o'eral o	11116	poter A.									

		Am	Please end item 19a per FH 11/	Type or Print in 14/2012 CCHD go State of Maryla	n Black II amend and / Deb	ndelible In item 10b artment of	k. Ensure	All Copie	es Are Le	gible.	40195
			- State Registrar			rtificate of			Reg. No.	114	+0130
	Physicia Medic		1 Decedent's Name (First Middle, Las	e			<u>.</u> .	2. Date of D	eath 2y	2012	3.21 PM
alama,	Examir	ner	4a. Facility Name (if not institution, give 5117 Maple Grove	Road		Hampst			4c. Cour Carr	nty of Death	ounty
	Funeral Director		5. Social Security Number 218–90–1760  Usual Residence of Decedent	PX 7. Age (In yr.	s. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		av. Yearl	9. Birthi Coun Mary	place (State or Foreign try) / Land
	Maryland 28a-f sho otifled at	Director	10a. State 10b. County Maryland Carrell Baltimo	-County H	City, Town or Lo Iampstea					1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	h with the ns 23a or nust be n	Funeral D	10e. Street and Number 5117 Maple Grove			10f. Zip Code 21074			10g. Citizen o United		
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Mimportant: If time 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	<u>۾</u>	11. Marital Status  1  Never Married 2 🔀 Married 3  Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🌠 No	an, Mexican, Puer	Specify Yes or No to Rican, etc.)		ace - Americ lack, White, o lify: Whi	etc.
Baltimore, Maryland 21215-0036	vithin 72 hc giene. er than "na the Medic	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4 or 5+)	(Give I	tent's Usual Occup kind of work done ( O NOT use retired) Naker	during most of wo	orking	16b. Kind of OWn 1		dustry
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e, Mar	and 2 should be Health and Men I 27 Is marke Ther traumatic		19a. Informant's Name/Relationship (Ty Paul E. Price /	husband	5117	ng Address (Street Maple Gr					
Itimor	ermit. Page 1 appartment of happartment of happartant: If its vy injury or ot		20a. Method of Disposition  1  Burial 2 X Cremation 3  4  Donation 5  Other (Specify	Removal from State		remation		Date 4, 2012		tead,	wn, State Maryland
Ba	Dermi Depar Impor eny ir		21. Signature of Funeral Service License	mo1		. Name and Addre 34 South		Eline Fu eet Har	neral Ho npstead	ome , Mary	land 21074
	nysician/ Medical Examiner	8 0	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	lications that caused the de le cause of each line.  a	TC	er the mode of dyin		c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Due to (or as a conse	equence of):						
		I= I	resulting in death) Last	Due to (or as a conse	equence of):						
Records, P.O. Box 68760	been signed by the attending physici should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1  Live Birth 2 Fe 4  Pregnant at time o 9  Unknown	etal death 3	Ectopic pregnance Other (specify)	.y			ate of delive	ry Day Year
ds, P.O.	en signed b	۵	Part II. Other significant conditions co	ntributing to death but not r	esulting in the ur	nderlying cause giv	ven in Part I.	23e. Did t	_ /		e cause of death?
Division of Vital Records,	ate has page 2	Completed						24a. Was auto perfo 1  Yes	psy ormed?	. Were autop prior to cor death? 1 \( \subseteq \text{Yes}	esy findings available npletion of cause of 2   No
ision of Vital	r this certificate I	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital: 1	☐ ER/Outpation	0.11	ace of Death (Che	ck only one)			
יוסר קיייייייייייייייייייייייייייייייייייי	h. After thi funeral		27. Mann of Death 1 Watural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at ?	28d. Describe			
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The Hospit	within 24 hours after To the Funeral Direc completely filled in b	Medical	only one) 3 Certifying Nurse	cian: To the best of my kno- er: On the basis of examinati Practitioner: To the best of	ion and/or investi	gation in my opinio	n death occurred	at the time date s	and place, and di	ue to the cau	cole) and manner stated
F	Co To		29b. Signature and title of certifier	Com	ng	29c. License	number	2	29d. Date signe	ed (Month, D	lay, Year)
	77-3	Ì	30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, Pr	int)	[1.	R/al	16.	Pro	21061
	State Registra	_	31. Date filed (Month, Day, Year)  NOV 1 4 201	32 Aegistrar's Sign	ature ba	eles	s in		STED	VIK	717

State of Maryland / Department of Health and Mental Hygiene $^{2}$   $^{\mathbb{C}}$ 

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** PIZOR 22, 2012 7:50 A M JANE C. November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Mount Airy Frederick Lorien Mount Airy If Under 1 Yes. Days 8. Date of Birth (Month, Day, Year) NOV • 19,1917 Birthplace (State or Foreign Country) If Unde Hours 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 ▼ F 95 Pennsylvania 163-16-0798 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ns 23a or 28a-f show must be notified at 1 XYes 2 □ No Directo Maryland Frederick Mount 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1008 Collindale 21771 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status "natural", or Items edical Examiner m Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Ite ury or other traumatic event, the Medical Examine. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 White <u>≽</u> 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Special Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert J. Colcord Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trains 1008 Collindale Ave./ Mount Airy, Maryland 21771 Karen P. Eckles /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 11/26/2012 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 8 E. Ridgeville Blvd./Mount Airy, MD 21771 23a. Part1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate ause (Final Physician STACE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Obstructive Pulmon Any Disease The law requires that the death certificate be executed ettending physician and or use as the burial-transit Division or Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 € No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 242 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hosisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of after death.

I Director: After to d in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a, Certifier ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 2012 23

Registrar

DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Midway Avenue, Mt. Airy. MO 21771

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0230M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin House Harwood Anne Arundel If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Director 577-42-3107 1 ⊠ M 2 □ F 77 1935 May 27, Washington, DC 27 is marked other then "natural", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3712 Webster Street 20722 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Master Plumber permit. Page 1 end 2 should be filed wit Department of Health and Mental Hygies Importent: If Item 27 is marked other 1 any injury or other traumatic event, in Own Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Irvin Price Savilla Swigart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3712 Webster Street, Brentwood, MD 20722 Ida May Price / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 11/25/12 Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onset and Death Physician/ UNG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or mjury Due to (or as a consequence of): signed by the attending physician end id be deteched for use es the burlel-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been sig , page 2 should b T☐ Yes 2☐ No 3☐ Probably 4☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy within 24 hours after death.

To the Funerel Director: After this certificate to completely filled in by the funeral director, page perform 2 No 1 ☐ Yes Yes 2 No Hoepitel or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) INPI MANDRIN Hospital: Other: 1 Tyes 2 No မှ CTR 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) 1. Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 23 2011 Tan 65M Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS MDV1401 31. Date filed (Month, Day, Year) LICHAE State Registrar -

DHMH 17 Rev 06-2011

**ORIGINAL** 

			For State	State of Maryland			ental Hygier	ne 2012	1,0198
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	Physicia		EUNICE	Pullins				Day Year	3. Time of Death
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	Funeval		Bultimure Wash 5. Social Security Number 6.5	iex 7. Age (In yrs. last)	Centry Cricin birthday) If Under 1 Year	150111C	. Date of Birth	HARE A	hplace (State or Foreign
	Funeral Director		1-1 21/21/20	□ M 2 <b>X</b> F 80	Months Days Yrs.	Hours Min.	(Month, Day, Yea	(O2) COL	intry)
	nd <b>how</b> at	'n	Usual Residence of Decedent  10a. State 10b. County	1 10c. City, To	own or Location		11 16 1	195 DUN.	10d. Inside City Limits
	Maryla 28a-f s otified	Director	MI Anne	Arundel C	Hen Bur	NE			1 Yes 2 🗆 No
	ith the	ralD	10e. Street and Number	1. 1 10	10f. Zip Code	117	10g.	Citizen of What Co	untry?
	eath w	Funeral	13. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of His	panic Origin? (Specify	y Yes or No-	14. Race - Amer	ican Indian,
36	after d I", or i	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give		n, Mexican, Puerto Ric Specify:	an, etc.)	Black, White	, etc.
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	15. Decedent's f	Year or Dates.	6a. Decedent's Usual Occupa	ution	16b	. Kind of Business/I	industry
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Ba	permit. Departn Importa any inju		21. Signature of Eureral Service Licen	W- 1901471	22. Name and Address	of Facility Farry		Home, Inc	7103
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	Examiner			ESSEN'T	TAL HYF	ERTE	NSION	ſ.	30YEARS
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09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours af er death.  To the Funeral Di ector. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dical		d					
687	ertifica ding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				22d Date of deli	
Box 687	e atten ed for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal de 4 Pregnant at time of deat	eath 3 🔲 Ectopic pregnancy	′		23d. Date of deli Month	Day Year
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J Of	ing Ph		27. Mann f Death 1   ✓ Natural 5   ☐ Pending		b. Time of 28c. Injury injury work?	at 280	d. Describe how in		
Sidr	Attend r death ector / by th	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home		Yes 2 □ No 281	f. Location (Street	and Number or Rur	al Route Number,
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	Hosp 24 hou Fune letely fi	Medical	(Check 2 \( \sum \) Medical Exam	sician: To the best of my knowledg iner: On the basis of examination an se Practitioner: To the best of my k	d/or investigation, in my opinior	n, death occurred at the	e time, date and pla	ace, and due to the c	ause(s) and manner stated.
	To the comp	2	29b. Signature and little of certifier	-Lap	29c. License			Date signed (Month	, Day, Year)
	3 500		2/000/	- r	20 DI	1160	No	VEMBER	21,2012
			30. Name and appress of person who	completely cause of death (Item)23,	Dype, Prins 410-	A KITCH	HIE H	19HW	+ 1/
ı	Stat Registra		31. Date filed (Month, Day, Year)	62. Registrar's Signaturé	back				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month Virgil L. Prezzi November 2012 12:40a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 615 Bowman Drive Wicomico Salisbury . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Months Days Hours Min **Director** 579-34-5112 1 🛛 M 2 🗆 F 05-26-1928 Washington, DC 84 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1 Yes 2 No MD Wicomico Salisbury ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 23a 21804 615 Bowman Drive United States 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 19 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1950þ 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 Year or Dates. 1952 1 ☐ Yes 2 No Specify: Specify: White 3 🗷 Widowed 4 🗌 Divorced "natural", Completed 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Dept. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Police Officer |Metropolitan Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nicholas Prezzi Lena Lorensetti and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 2910 Marston Rd. New Windsor, MD 21776 Earlene Bradford/ Daughter 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Ft.Lincoln Crematory 11-28-12 permit. 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Ineral Servic 3401 Bladensburg Rd Brentwood, MD 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1 Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ signed by the atter in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tyes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 은 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify, 27. Manne Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Matural 5 Pending work 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 🗌 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/on investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERN

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GLORIA E. POOLE 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MIONAL dicimico 506156114 TENINSULA cial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 218-48-7998 Director 1 □ M 2 🛱 F 63 11/30/48 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Wicomico Salisbury 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 27340 Walnut Tree Road 21801 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Homes 12 Nanny Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hillary Dorothy Ellen Williams Orville Pryor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8660 Poole Street, Delmar, MD Orville Poole/Son permit. Page 1 and 2 Department of Health Important: If Item 27 any Injury or other tr once. timore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cernetery, crematory or other place, 11/26/12 Mid Shore Cre.Ctr. Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee 22, Name and Address of Facility 21.613 Mid Shore Cremation Center, Cambridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Romiovasca Physician/ EP1 > 4 disease or condition new Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Z4 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit eleip filled in by the funeral director, page 2 should be detached for use as the burial-transit this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Sinknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 💢 No ျှ 1 ☐ Inpatient 2 🕅 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 3 🗆 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signay 29d. Date signed d address of person who completed cause of death (Item 23a) (Type, Print) note Ma 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MOV Registrar

eanor ciame r		State of Maryland / Department of 1- For State Certificate of Registrar		na ivientai		eg. No. 201	2 + 120					
Physicia edical Exami		1. Decedent's Name (First, Middle,Last)  Eleanor Elaine Pressley		-	2. Date of Dea Month	ath Day Year er 19, 2012	3. Time of Death 1729 hrs					
		4a. Facility Name (if not institution, give street and number)	lb. City, Town, o	or Location of De		4c. County of Dea	th					
		6323 Ganeys Warf Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Preston  If Under 1 Ye	ar If Under 24	Ura R Data of Ri	Caroline orth(MM/DD/YYYY) 9. B	irthologo (State or					
Funeral Director		214-36-6161 <sub>1 M 2 X F</sub> 75 Yrs.	Months Da				ign Maryland					
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the Mary 3a or 28a- otified at	Director	10e. Street and Number 6323 Ganeys Wharf Road	10f. Zip Code	21655		10g. Citizen of What Co United Stat	•					
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marthal Hygier than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Ye	s Decedent of Hes, specify Cuba	an, Mexican, Pu	( Specify Yes or No erto Rican, etc.)	White, etc.	erican Indian, Black, White					
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MD 21215-0036 d 2 should be filed within 7 thth and Mental Hygiene. n 27 is marked other than numatic event, the Medical	Be	17. Father's Name (First, Middle, Last) William Harold Chance		Lucy l	ame (First, Middle, May Hubba	ırd						
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Baltimore, permit. Pages I an Department of Hea Important: If iter	k 20	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	ame and Addres	ss of Facility	Framptom Federal	Funeral Hollsburg, MD	me, P.A. 21632					
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Bue to (or as a consequence of):	ovascular Di	isease	-10		Between Onset and Death					
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/		ner (Specify)									
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Division of Vital Records, P.O. Box 68760, at or Attending Physician: The law requires that the death certificate be executed reacher. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - trans	Completed					psy prior to ormed? death?	autopsy findings available completion of cause of					
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ion (tendin death. A tor: A	ation	1 V Natural 5 Pending 2 Accident Investigation (Month, Day,Year)	1	Yes 2 No								
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined (Specify)	t, factory, office	building, etc.	28f. Location ( or Town,		Rural Route Number, City					
the Hos hin 24 h the Fun upletely	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurr one)  2 Medical Examiner: On the basis of examination and/or investigation.										
To To com	Mec	29b. Signature and title of certifier		nse number		29d. Date signed (M	<u> </u>					
		30. Name and address of person who completed cause of death (Item 23a)	, O.C	.M.E.	OCIME	November 20, 2	2012					
		Theodore M. King, Jr., MD. Assistant Medical Examiner	900 W. Balti	more Street	, Baltimore, M	D 21223						
St Regist	tate	31. Date filed (Month, Day, Year) 32. Redistrar's Signature		· ·	<del></del>							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 8 2012 11:02 AM F. Rossulek Alexander Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 118-40-4382 Director 1 X M 2 □ F Yrs Sept. 25, 1940 Czechoslovakia 72 Usual Residence of Deced or than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. Count 10d. Inside City Limits Director 1 Yes 2 K No Maryland Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 United States 8037 Old Receiver Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give should be filed within 72 hours after of and Mental Hyglene. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Equipment Marketing Manager traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maria Netroufal Alexander Rossulek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sift Health a item 27 i 8037 Old Receiver Road Frederick, Maryland 21702 Patricia Rossulek / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite any Injury or ott November 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 14, 2012 Stauffer Crematory Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 23a. Part 1. Pier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Frederick, Maryland 21702 Approximate Onset and Death Physician/ Due of r as a consequence of): Medical resulting in death) Examiner (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events. Examin carotid artery burial-transit that initiated events Due to (or as a consequence of resulting in death) Last ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 9 cate has been sig 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 🕱 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 K ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

68760 Box Records, Division of Vital To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral

> 0, Registrar

Montegnery 31. Date filed (Month, Day, Year) State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

metmon

(Check only one)

> ,7190 Crestwood Blvd, Frederick, MD 21703 Cornelicon 32. Registrar's Signature

2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D72798

29d. Date signed (Month, Day, Year)

November, 9

			State of Maryland / Department  State of Maryland / Department  Certificate			2014	40203
ı	Physicia		1. Decedent's Name (First, Middle, Last) William Reeves	0.200	2. Date of Death	Day Voor	3. Time of Death 2:30 A M
$\langle$	Medic Examin			own, or Location of Death  y Point		4c. County of Death St. Mary	
	Funeral Director		5. Social Security Number 400 60 6833   Usual Residence of Decedent   6. Sex 7. Age (In yrs. last birthday) If Under Months 69 Yrs.	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye 07/06/1	9. Birthplace ear) Country,	ce (State or Foreign
	aryland a-f show fied at	Director	10a. State 10b. County 10c. City, Town or Location  MD St. Mary's Piney Point			10d	. Inside City Limits
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	ems 23	Funeral	13033 2240111022 0041	20674  nt of Hispanic Origin? (Spe		USA 14. Race - American	Indian
036	's after de ral", or it Examine	þ	1 ☐ Never Married 2 ☐ Married 1 1 2 Yes 2 ☐ No	nt of Hispanic Origin? (Spery Cuban, Mexican, Puerto F  ☑ No Specify:	Rican, etc.)	Black, White, etc	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use it	done during most of workir etired)	ng	6b. Kind of Business/Indus	stry
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rylar	ould be 1 d Menta marked matic e	To	X.L. Reeves  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (		uise Wi		
, <b>M</b> a	nd 2 sho ealth an n 27 is er traui		Too! Hamily radiooo!	Street and Number or Rural ackwell Ct.			
imore	Page 1 ar ment of He <b>ant: If iter</b> ury or oth		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name cemetery, crematory or off KY Veterans			oc. Location - City or Towr	
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee 22. Name and 38576	<sup>Address of Facility</sup> Bri Brett Way	scoe-To	nic Funer	al Home
P	hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)			In	pproximate terval Between nset and Death
2	Medical Examiner	i	resulting in death)  Due to (or as a consequence of):				
7	sit	Examiner	Sequentially list conditions, if any 1 daily 1				
0	ite be executed hysician and the burial-transit		Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
3760	g physic as the b	Medical	d				
Box 687	requires that the death certificat been signed by the attending ph should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pr 4 ☐ Pregnant at time of death 5 ☐ Other (spe			23d. Date of delivery Month Da	ıy Year
P.O.	ne raw requires that the death ate has been signed by the atte page 2 should be detached for	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.		co use contribute to the c	
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Reco	certificate has b	Completed			autopsy performed	prior to comp death?	letion of cause of
Vital	s certific director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DO/	26. Place of Death (Check		e 6 Other (Specify)	
n of	After thi funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury 28b. Time of injury		8d. Describe how i		
Division of Vital Records,	after deaf  Director: d in by the	Certificate:	2 Accident 3 Suicide 4 Homicide 1 Investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Rural Ro tate)	ute Number,
T stinger	untriply to Arenaum or Arenaum virtuals:  Within 24 hours after death.  To the Funeral Director: After this certification of the funeral director, completely filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred at the only one)  3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the only one)	y opinion, death occurred at	the time, date and p	lace, and due to the cause	(s) and manner stated.
F 0	To th	-	29b. Signature and title of certifier 29c.	_ 0071412	29d.	Date signed (Month, Day	; Year)
8	D'X1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Or Bilal Ahmed, MD 110 Hospital F				
	Stat Registra	e	31. Date filed (Month, Day, Year) 6 2012 32 fiegistrar's Signatury 9. parks				20070

12-09005 Margaret Kubast	a R	Please Tyj					n <b>k. Ensur</b> Health an						0 / 000
		1- For State Registrar				ificate of				Re	g. No.	. U I	2 4020
Physicia Medical Exami		1. Decedent's Name (First, Midd Margaret Kuba		ndall						Date of Death Month November		/ear	3. Time of Death 1305 hrs
	ı	4a. Facility Name (if not institution Meritus Medical Cent	_	and number)		(	4b. City, Town, or Hagerstowi					ty of Death ington	
Funeral Director		5. Social Security Number 396-05-2159	6. Sex		(In yrs. las	t birthday) Yrs	Months Day			3. Date of Birth June 1	•	Foreir	thplace (State or InWisconsin untry)
ķ		Usual Residence of Decedent  10a. State 10b. County			Oc City T	own or Locati	ion						10d. Inside City Limits
land f shnw an nnce.	ě	Maryland Washi	ngton	<u>_</u>	•	erstow	n						1 X Yes 2 No
1 the Mary 3a or 28a	Direc	10e. Street and Number 1041 St. Clair	St.				10f. Zip Code 2174	2		10	10g. Citizen of What Country? U.S.A.		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", nr items 23a or 28a-f shnw any injury nr nther traumatic event, the Medical Examiner must be notified at nince.	<b>Funeral Director</b>		larried Arr		ver in U.S No		s Decedent of Hi es, specify Cuba Yes 2 X No	n, Mexican	, Puerto Rio			hite, etc.	can Indian, Black, White
ours aft atural"	ğ	15. Decedent's Education (Spe	or Dates		leted)		it's Usual Occupa	tion (Give	kind of wor		16b. Kind of		
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MD 21 12 should th and Me 1.27 is ma umatic co	٩	19a. Informant's Name/Relations Virginia R. Ta			er		St. Cla						
nore, ages land of Heal	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Smithsburg Crematory 11-29-2012 Smiths										-		
22. Name and Address of Facility Douglas A. Fiery										y Fur	eral Home		
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/Medical xaminer		failure List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Ischen	nic Bowel v									Between Onset and Death
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ords, P.O. Box 68760, w requires that the death certificate be executed its been signed by the attending physician and should be detached for use as the burial - transit	_	UNPENDED	d AMEN	DED									
18760 Tificate b mg physicas the bu	an/Me	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	ho -	f yes, outcome Live birth	of pregna	. —	tal death 3	Ectopi	c pregnanc	y	23d. Date Month	of deliver	y Day Year
Box 68760 to death certificate by the attending physical for use as the burse the burse as the b	Physician/Medica		known 9	Pregnant at tie Unknown	me of dea	th 5 Ot	her (Specify)						
P.O. s that the	Ď	Part II. Other significant condi High Blood Pressue,					underlying cause Hip Fracture	-	art I.				the cause of death?
ords, w require us been si	Completed	complications				, , , , , , , , , , , , , , , , , , , ,				24a. Was a	sy	prior to	utopsy findings available completion of cause of
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1 of Vital Recing Physician: The After this certificate funeral director, page	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No		1 Inpatient	t 2 [	ER/Outpatient		Other <sub>4</sub>	(Check onl		Residence 6	6 Othe	r:
Division of Vital Records, P.O. taal or Attending Physician: The law requires that the star death.  Al Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detach	tion: T	27. Manner of Death  1 Natural 5 Pen	ding 28a	Date of Injury (Month, Day Yes V 7, 2012	/	28b. Time of I 0200 hrs		ıry at Worl	.  Sı	3d. Describe h ubject fell a			
Division of Att is after de la Directo led in by t	Certification:	3 Suicide 6 Cou	lid not be	e. Place of Inju	-		et, factory, office	building, e	tc. 28	or Town, S 14 Marsh P	Street and Nuitate)	mber or Ru	ural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Functal Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical Co	29a. Certifier 1 Certifying F	Physician: To t	he best of my basis of exami	knowledge	e, death occu	rred at the time, o		ace, and du	e to the caus	e(s) and man	ner as stat	ed.
To To com	Mec	29b. Signature and title of certifi		nner stated.			29c. Licen		Unid				nth, Day, Year)
		30! Name and address of person	n who complete	d capte of de	ath (Itém :	14. D	, 0.0	M.E.			Novemb	er 27, 2	U 1 Z
JW-5		Theodore M. King, Jr	., MD. As	ssistant Me	dical E	xaminer	900 W. Baltii	more St	reet, Balt	timore, MD	21223		
St	ate	31. Date filed (Month, Bay, Year)	2019	32. Registrar's	s Signatur	es s	a shall						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#20b per FH 1 - State 11/28/2012 AACO HEALTH DEPT CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical or Location of Death Examiner Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral Director** 021-28-1251 1 X M 2 D F October 24,1935<sub>Massachusetts</sub> 77 ?7 is marked other than "naturai", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director 1 X Yes 2 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2929 Stonybrook Drive 20715 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 TM Married 1 V Yes 2 No
If Yes, Give
Year or Dates, 1958-78 Baltimore, Maryland 21215-0036 1 ☐ Yes 2) ☐ No Specify. 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Intelligence Analyst U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Granville Hill Robinson Margaret Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Margaret M. Robinson/Wife <u>2929 Stonybrook Drive Bowie MD.</u> 20715 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National 20a. Method of Disposition permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 2/11/2013 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <del>Unknown</del> Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRobert E. Evans Funeral Home 16000 Annapolis Road Bowie MD, 20715 Dir 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of, that the death certificate be executed Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 des 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the Hospital or Attending Physician: The this certificate 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Donatient 2 ER/Outpatient 3 DOA မှ completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation within 24 hours after deatl To the Funeral Director: 3 D Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, ans St. appelli MD aura

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1401 P M Ernest James Reed DECEMBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAL HOSPITAL OF BACTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 235-52-3652 Director 1 X M 2 □ F 79 10/16/1933 WV Usual Residence of Decedent filed within 72 hours after death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Director Adams Fairfield PA 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 50 Walnut Trail 17320 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other treumatic event, the Magnobies. Elementary/Secondary (0-12) College (1-4 or 5+) machinist Continental Can Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawson Reed Almeda Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
50 Walnut Trail, Fairfield, PA 17320 Kathleen Reed/wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Emmitsburg Mem. Cem. 12/7/2012 Emmitsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address Pridtes Funeral Home and Chapel, PA 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician SEPSIS DAYS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an PERIPHERAL VASCULAR DISEASE DIABETES MELLITUS Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🖳 No 1 Yes မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Veten W. Cho Surgeon 141129 DECEMBER 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER W. CHO MD 2435 WEST BELVEDERE AVENUE BALTMONE MANYLAND 21215 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kember 01:30 M Albert Thomas Rowlette, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Hagerstown Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Year) Hours Country) Director 409-54-0151 1 X M 2 □ F Yrs 80 10/17/1932 TN Usual Residence of Decedent or then "netural", or Items 23e or 28e-f show the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Hancock Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA S.E. 21750 11640 Ziegler Road, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ۵ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Car Manufacture 12 Assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be filed nt of Health and Mental H I: If Item 27 is merked ot မ Mary Morelock Chester Rowlette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ziegler RD, S.E. Hancock, MD 21750 <u> Helen M.Rowlette/Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 e
Derartment of H
Imcortent: If Ite
any Injury or ott 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 12/04/2012 Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 141 WEst Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 M00260 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final bresumed Physician/ disease or condition resulting in death) acute Medical Due to (or as a consequence of): Examiner cond Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami stepe attending physician and I for use es the burlai-transit or Attending Physicien: The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) sete has been signed by the signage 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificete 2 🗆 No 1 🗌 Yes funeral director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O မှ 1 Department 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospitel or Attending within 24 hours effer death.

To the Funerel Director: Afte 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 12/03/2012 062440 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

of Vital

Division

MO

32. Registrar's Signature

1116 Medical Campis Rd

			For State	5	State of M	aryland	-	artment of I tificate of I		and M			201	2	40208
		7	Registrar  1. Decedent's Name (First, N	Journ	Reg. No.  2. Date of Death  3. Time of Death										
	Physicia Medic	al	Mark D				Nov 24,			i_	8:17 A <sup>M</sup>				
	Examir	er	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location  Prince George's Hospital Center  Chever1v										County of De		Q
×	Funeral Director		5. Social Security Number  216 92 2752  Usual Residence of Decede	6. Sex 1 □ <b>X</b> M		ge (In yrs. las	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Nov 7,	Birth 9. Birthpl Day, Year) Counti			e (State or Foreign	
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	with th	Funeral I	10e. Street and Number $14209 \ Re$	ectory La	en			2077	2			-	zen of What <b>United</b> S	-	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 XX Never Married 2   3  Widowed 4 Divo	Married	Was Decedent Armed Forces? 1 Yes 2 The If Yes, Give Year or Dates.		11	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 X No	an, Mexicar	n, Puerto F			14. Race - Ar Black, Wl Specify: W	hite, etc.	Indian,
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aryk	should be file and Mental I 7 is marked or raumatic eve		19a. Informant's Name/Relati				19b. Mailin	g Address (Street	and Numbe		ta Eilee Route Numbe			Zip Cod	(e)
ž,	and 2 sho Health an <b>tem 27 is</b> other trau		Donald Strine (	father)			I	09 Rectory							·
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09,	ate be executed physician and the burial-transit	edical E	resulting at death) Last	L <sub>d.</sub>		a conseque									
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Division	al or Atte s after de il Directo ed in by th														ute Number,
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	2013		30. Name and address of per	son who comp	oleted cause of c	death (Item	23a) (Type, P		269	301	1	1001	rember	-6	7. 6016
	An		Dr. B. Co 31. Date filed (Month. Day Ye	1e =	300/ f	403p	1/a/	Drive C	here	dy.	M.D.	207	85		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2001 2

			For State Of 28	aryland, Depa <b>a-b, 28e, pe</b> i Cer	r me, g935 tificate of L	ieaith and I-I7-I3 Death	sm.	Reg. No.	12 40209			
ł	Physicia		Decedent's Name (First, Middle, Last)  Sean Dayar.  Output  Dayar.	nni Sa	rter		2. Date of Dea		3. Time of Death 012 11:21Р м			
	Medic Examin		4a. Facility Name (if not institution, give street and number) 4613 Scottsdale Place			Location of Death		4c. County of				
	Funeral Director	Г	5. Social Security Number 6. Sex 7. Age 1213 13 8995 8. Sex 1 X M 2 F	(In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	9. Birthplace (State or Foreign Country)  DC			
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	th the Na or 2	al Di	10e. Street and Number 4613 Scottsdale Place		10f. Zip Code 2060	12		10g. Citizen of Wh	nat Country?			
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Baltimore, Maryland 21215-0036			20a. Method of Disposition  1   → Burial 2   → Cremation 3   → Removal from State 4   → Donation 5   → Other (Specify)	Heritage	natory or other place  Mem. Ce	em. 12/3		Waldor	•			
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_	icate be executed physician and is the burial-transit	edical Examiner	that initiated events resulting in death) Last	consequence of):				<u>-</u>				
3760	ficate g phys		d									
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		State of Maryland / Department of Health and Mental Hygiene 2 U 2  1 - State Registrar Certificate of Death Reg. No.										90210			
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	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 or	Medical			Physician: To the bes										
	To the Ha within 24 To the Fu complete	Med	only one) 3	☐ Certifying	Examiner: On the basis g Nurse Practioner: To			leath occurred at	the time, date and p		he cause(s) ar	nd manner as st	ated.		
	<b>6 6 6</b>		29b. Signature and t	itle of certifie	MA				6176	29d. Date signed (Month, Day, Year)					
	3				who completed cause	of death (Iter	n 23a) (Type, P	rint)		MA C : -		-			
	Stat	e	31. Date filed (Month	orma, in, Day, Year)	32. Reg	iştrar's Signa	ature .	DOW SE,	Eikten,	MD 219	121	-			
	Registra			NOV	3 0 2012	Green	B. 7	gearen							

			For State	State of M	larylan					and M	lental Hy	giene	20	1 0	. 0	011	
	-	1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)									Reg. No. 2. Date of Death 3. Time of Death						
	Physicia		FRANKLIN	R					Month NOVEMBI		3, 20	ear	7:50				
	Medic Examin		4a. Facility Name (if not institution, give	street and number)			4b. City,	Town, or	Location of				County of		7.50		
~	/		1 CIRCLE DRIVE						DEPO					CIL			
	Funeral Director		5. Social Security Number 6. S	ex 7. Ag X M 2 🗆 F	je (In yrs. li 90	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	v. Year)		Count	lace (State o		
			213–18–3052 Usual Residence of Decedent								NOV 05	, 19	22 ]	MAI	RYLAND		
	yland f sho	ctor	10a. State 10b. County		10c. Cit	y, Town or Loc	ation							10	Od. Inside Cit		
	r 28a	Director	MARYLAND CEC	<u>I</u> L			POR'		POSIT	1			5140			2 X No	
	vith th	ıral	1 CIRCLE DRIV	Ξ			Tion. Zip	2190	04			_	zen of Wh				
	within 72 hours after death with the Maryland giene. Ier than "natural", or items 23a or 28a-f sho is the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S		Vas Decede	ent of His	panic Orig	in? (Spec	cify Yes or No-		14. Race -	America	an Indian,		
36	after d ", or i	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	No		Yes, speci			, Puerto F	Rican, etc.)			White, e			
21215-0036	ours a atural	Completed	3 X Widowed 4 Divorced  15. Decedent's E	Year or Dates.										BLA			
215	n 72 h s. an "n Medi	mpl	(Specify only highest gr Elementary/Seconday (0-12)		5+)	(Give k	Decedent's Usual Occupation 16b. R Give kind of work done during most of working ife. DO NOT use retired)						Kind of Business Industry				
	l withi		7		J 1)	BOII	ER TI	ECHŅ.						US NAVAL BASE			
and	ould be filed within 72 hours after the Mental Hygiene. marked other than "natural", matic event, the Medical Exar	To Be	17. Father's Name (First, Middle, Last)  DANTEL STEWART								(First, Middle,	Maiden S	Surname)				
Maryland	ould b nd Mer mark matic		19a. Informant's Name/Relationship (7	voe Print)		10b Mailin	a Addross	/Street or			THOMAS  Route Number	r City or	Town Stat	o Zio C	odo)		
	and 2 shoul Health and I tem 27 is mother traumon		FRANKLIN H. STEWA		SON		•				EPOSIT,				,		
Jre,	of Heg of Heg fitem		20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3		20b. F	Place of Disposemetery, crem	sition (Nam	e of	1		ate		cation - Ci				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "matural", or items 23a or 28a-f show amportant in injury or other traumatic event, the Medical Examiner must be notified at once.	Ц	4 Donation 5 Other (Special	fy)		ZOAR Z	AME C	EME'I'	ERY		1/12			O, N	IARYLAI	ND	
Ball	permit. Departr Importa any inju		21. Signature of Funeral Service Licens	see		22	Name and	Address SCOT	of Facility	NERAI	L HOME,	P.A					
			23a. Part 1. Enter the disease, or com	plications that caused	the deat	~	552_1	I-W IS	SIR	EET.	HAVRE:	DE G	RACE,	MD	21078 Approximate		
5	Pnysician/	3 8	shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line	e.						,			ļ	Interval Bety Onset and D	ween	
	Medical		disease or condition resulting in death)	a. Due to (or as	a contequ	uence of):	STAC	2=						+			
	Examiner	<u>.</u>	Sequentially list conditions,	b. ———										_			
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):											
V	xecute n and al-tran	Exa	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):								+			
09	ath certificate be executed attending physician and for use as the burial-transit	dical		l d													
6876	rtificat ing ph e as th	/Mec	IF FEMALE:	00-16	-6												
Box (	ath ce attend for us	cian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	aldeath 3 🗌	Ectopic p		,			2	23d. Date of Month		delivery Day Year		
Ö.	the des by the stached t	Physician/Me	1 Yes 2 No g Unknown	g 🗌 Unknown													
P.O.	es that i		Part II. Other significant conditions of	-	out not res	ulting in the ur	nderlying c	ause give	en in Part I.		A -00*				e cause of de		
rds,	require been signal	ted	LUNG CANC	EK							1/4	Yes 2[	□ No 3	Prob	ably 4 □ l	Jnknown	
000	has by	Completed by	DIABETES A	1ELLITU	5						24a. Was a autop		pric		sy findings a npletion of ca		
Ä	ician: The la certificate ha rector, page ;		25. Was case referred to medical					26 Pla	ce of Death	Chock	1 🗌 Yes	2 No		Yes :	? □ No		
Vita	ysician: is certific director,	To Be	examiner? 1 ☐ Yes 2 X No	Hospital:	ent 2 🗆	ER/Outpatien	t 3 🗆 DO	Othor			ne 5 Resid	ence 6	Other (	Specify)			
of	ng Ph fter th ineral		27. Manner of Death  1 Natural 5 Pending	28a. Date of inju (Month, Da	iry	28b. Time of injury		Bc. Injury work?	at		8d. Describe h			1			
ion	r Attending F ter death. rector: After by the funera	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b		un. At ho	mo form atra	M et facten:		′es 2 🗌 ľ	-	006 L 15 40	44	Africantes	n December	Davida Abrash		
Division of Vital Records,	I or A after Direct		4  Homicide determined	building, etc	c. (Specify	)	et, lactory,	Office		'	8f. Location (S City or Town		Number C	r nurar r	toute Number	er,	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical)Exam	sician: To the best of iner: On the basis of e	my knowl	edge, death o	ccured at t	he time, o	date and p	lace, and	due to the cau	use(s) and	manner a	s stated	sp(c) and ma	nnor etator	
	the H thin 24 the F mplete	Me	only one) 3 Certifying Nur	se Practioner: To the			eath occurr	ed at the	time, date a		, and due to the	e cause(s)	and mann	er as sta	ted.	,, or stated.	
	<b>6</b> .≱ 6 0		29b. Signature and title of certifier		MI	À		License		u		29d. Date signed (Month, Day, Year)					
			30. Name and address of person who	completed cause of d	eath (Item	23a) (Type, Pi			34	7		// /	<u> </u>	1"4			
	7		SURESH DHA	NJANIO	4D.	622	S, y	NIO	N AL	VE,	4AVRE	DE	CRA	CE	MD21	1028	
	Stat Registra		31. Date filed (Month, Day, Year)  NOV 2.7	32. Registra	ar's Signat	ure		4		,							
			MUY 2.7	/ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		27 /	Cata Ma	No. of Street, or other Persons									

DHMH 17 Rev 7/2009

Concept   Conc				For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of rtificate of	Health ai Death		giene	12 40212				
## Manuel Stanley, Jr.  ## Stanley and processor of Consults    Stanley and processor of Consults					Last)										
4. County of Carlot  Tournal District  Tournal D				Manuel S	Stanley. Jr					1520					
Provided   Provided							4b. City, Town,	or Location of							
S. Social Security Number  219—36-1874  100-380	п			255 Walnut Gar	den Road		Risin	g Sun		Ce	cil				
Particle   Particle		Funeral		5. Social Security Number		ge (In yrs. last birthday	) If Under 1 Year	r If Under 2	4 Hrs. 8. Date of Bir	th v. Year)	Birthplace (State or Foreign Country)				
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18 Burial 2   Coremation 3   Defense (Speechy)   Silverbrook Cem.   Nov.21,2012   Wilmington, DE		alth alth 27 is 27 is ser tra		Samuel Morris S	stanley (so	n) 3	36 E. Vie	w Drive	e Elkton, l	MD 219	21				
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Physician   Phys	aĦ	mit. partn ports y inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility											
23. Pain. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Physician (Medical Examiner)  The distribution of the complete of the mode of dying, such as cardiac or respiratory arrest.  Physician (Medical Examiner)  The distribution of the complete of the mode of dying, such as cardiac or respiratory arrest.  Physician (Medical Examiner)  The distribution of the complete of the mode of dying, such as cardiac or respiratory arrest.  Physician (Medical Examiner)  The distribution of the complete of the mode of dying, such as cardiac or respiratory arrest.  Physician (Medical Examiner)  The distribution of the complete of the mode of dying, such as cardiac or respiratory arrest.  Physician (Medical Examiner)  The distribution of the complete o	Ω	99 6 8 8		micolo D	Ticalle	elli	_				_ ·				
Physician / Medical Examiner    Physician / Medical Examiner				23a. Parvi. Enter the disease, or o	complications that cause	ed the death. Do not en	nter the mode of dy	ring, such as c	ardiac or respiratory a	rrest,	Approximate Interval Between				
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Female   Part     rt     Part   Part   Part     Part		cuted nd ransi	ä	that initiated events											
FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   4   Pregnant at time of death   5   Other (specify)   1   Yes   2   No   9   Unknown   9   Unknown   9   Unknown   9   Unknown   1   Yes   2   No   9   Unknown   9   Unknown   9   Unknown   1   Yes   2   No   9   Unknown   1   Yes   2   No   9   Unknown   1   Yes   2   No   3   Probably   4   Unknown   1   Yes   2   No   3   Probably   4   Unknown   2   Year   2	ó	an al		resulting in death) Last	Due to (or a	s a consequence of):									
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25. Was case referred to medical examiner?	9	ng ph as t	Med	IS SEMALE:											
25. Was case referred to medical examiner?	õ	th ce tendi	an/I	23b. Was decedent pregnant			□Ectopic pregnan	су							
25. Was case referred to medical examiner?		e dea he at	sici	1 ☐ Yes 2 ☐ No		at time of death 5	Other (specify)				July 194				
25. Was case referred to medical examiner?	P.O.	at the	Phy			- Lib. A. I. Abo and of death?									
25. Was case referred to medical examiner?		es th igned		Part II. Other significant condition	is contributing to death	but not resulting in the	underlying cause g	liven in Part I.		1/					
25. Was case referred to medical examiner?	bro	equir ould	ted							Tes ZIAINO	3 Plobably 4 Dollkilowii				
25. Was case referred to medical examiner?	S S	lawr asbe 2sh	ble	1							prior to completion of cause of				
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The state of light of the light	ita	ian: artific ctor,	a					26. Place	of Death (Check only	one)					
Composition of the content of the	>	hysic nis ce I dire		_ /	1 U Inpai		IN SU DON	4 🗀 Nui:	sing Home 5 Sesi	dence 6 □O	ther (Specify)				
2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homic	0 0	ng Pl fter ti nera			28a. Date of In (Month, D	jury 28b. Time lay Year) Injury				how injury occu	ırred				
29a. Certifier  29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	Si Oi	andii sath. or: A he fu	atle	2 Accident investig	ation		M 1[	JYes 2□N							
29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29b. September 29a. Certifier 29a. Certifier 29b. September 29a. Certifier 29a. Certifier 29a. Certifier 29b. September 29a. Certifier 29a. Certifier 29b. September 29a. Certifier 29b. September 29a. Certifier 29a. Certifier 29b. September 29a. Certifier 29a. Certifier 29b. September 29a. Certifier 29b. September 29a. Certifier 29c. September 29a. Certifier 29c. September 29a. Certifier 29b. September 29a. Certifier 29c. September 29a. Certifier 20c. S	<u>₹</u>	r Att ler de iract	Ĭ	datami	286. Place of I	njury - At home, farm, s etc. (Specify)	treet, factory, office	Э			iber or Rural Route Number,				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dudress of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only of Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	0	ital o							<u> </u>						
and manner stated.  29b. Signature and title of certifier  DO4B23  29c. License number  29d. Date signed (Month, Day, Year)  L1/20/2012  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TVI CHHHHSUMD 22-3 West main 4. Elkhom 11 2 192 1  31. Date filed (Month, Day, Year)  32. Registrar's Signature		d hou thou unai	ica	(Check only 2 Medical E	xaminer: On the basis	of examination and/or i	th occurred at the nvestigation, in my	time, date and opinion, death	I place, and due to the n occurred at the time,	cause(s) and n date and place	nanner as stated.  e, and due to the cause(s)				
290. Signature and title of certifier  DO 48:23  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TVI CHHHHSU MD 22-3 West many St. Elkforn M.J. 2.19.2.1  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		the Inin 24 the Inin 24 the Inplete	Jed	one)		stated.									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ronald Medical Campbell Smith 201 48 Jovember 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 8. Date of Birth Nov. 12, 1946 If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Hours 141-42-7754 66 Min. 1 AM 2 D F Director Connecticut 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene.
I item 27 is marked other then "natural", or items 23e or 28a-f show other traumatic event, the Wedical Examiner must be retified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Frederick Frederick 1 No Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1405 Dagerwing Place 21703 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Juvenile Services æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Ronald E. Smith Loriel Buck permit. Page 1 and 2 should be Department of Health and Ment important: if item 27 is marke eny injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 Dagerwing Place, Frederick, MD 21703 19a. Informant's Name/Relationship (Type, Print) Mrs. Sally W. Smith, wife Baltimore, 20a. Method of Disposition
1 

Burial 2 Cremation 3 

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematory Nov. 28, 2012 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Live <sup>23</sup>්රීම්පිරිම්ප්රිත් PA Funeral Home M00255 106 East Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY ARTERY DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) anding physician and use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown ò Month Day signed by the at d be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an his certificete has ball director, page 2 s autopsy performed?
☐ Yes 2 🖾 No death? 1 Yes 2 No Hospitai or Attending Physician: Division of Vital 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 X Yes 2 No 읻 1 Inpatient 2 KER/Outpatient 3 I DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🖄 Natural 5 Pending ours after death.
erai Director: Aff 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D068843 ( Kellin & 11/21/2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARNEGIE 568, BALTIMORE, MD 21287 HWANG CHAO-WEI 600 NORTH WOLFE ST.,

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

NOV 2.6

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of M	aryian	•				rientai Hy	/gien	е			
			Registrar  1. Decedent's Name (First, Middle, La	st)		Certificate of Death Reg. No.									
	Physicia		Ira Willi	,	omley					Month Novemb		av 20.	ear	3. Time of Death 7:20 A M	
Marie .	Medic		4a. Facility Name (if not institution, give		4b. City. To	tion of Death		c. County of		7.20 A					
	)		4427 Valley View	Road				lletow				Frede		c	
	Funeral		Social Security Number 6. 8		e (In yrs. la	ast birthday)	If Under 1	Year If U	nder 24 Hrs.	8. Date of Birth		9	. Birthol	ace (State or Foreign	
	Director			I 🖾 M 2 🗆 F	(7	Yrs.	Months	Days Hou	urs Min.	(Month, Da			Counti	**	
	P MON		Usual Residence of Decedent  10a. State 10b. County		67	v. Town or Loc	ntion			Oct. 1	2,	1945		yland	
	rylan F sh	용			Toc. City	,							10	Od. Inside City Limits	
	e Ma	뚪	Maryland Freder  10e. Street and Number	ick		Mid	dletov							1 ☐ Yes 2 🔯 No	
	######################################	교		D 1			101. Zip C					Citizen of Wha		•	
	ath w	Funeral Director	4427 Valley View	12. Was Decedent	Ever in IIS	13 V	Vas Deceder	21769	c Origin? (Spe	cify Vee or No-		United			
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is merked other than "netural", or items 23e or 28e-f show any injury or other treumetic event, the Medical Examinat must be notified at once.	Completed by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.		H	Was Decedent of Hispanic Origin? (Specify Yes or NIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:					14. Race - A Black, N Specify:	White, e		
5	"net	음	15. Decedent's E (Specify only highest gr	Education rade completed)		16a. Deced	ent's Usual (	Occupation done during	most of worki	na	16b.	Kind of Busin	ess/Ind	ustry	
121	thin 7	녌	Elementary/Secondary (0-12)	College (1-4 or	5+)	life. DO	O NOT use re	etired)				0		. •	
42	Hygie other	Be	10 17. Father's Name (First, Middle, Last)				rickla		d-di-ni- Ni-			Construction			
an	be file	2	Guy Robert Swoml	0.77				18. 1		e (First, Middle, rine Mi		n Surname)			
₹	ould mer		19a. Informant's Name/Relationship (			10b Mailin	a Addrona (F	Street and Ali					7:0		
Š	27 is			Tob. Walling Address Cheet and Number of Harar Notice Number, City of											
ē,	1 and f Hee item othe	0.1	20a. Method of Disposition		20b. P	lace of Dispos	sition (Name	of		Date		Location - Cit			
Ę	age 1 ent of nt: If i		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State		emetery, crem uffer			11/2	3/2012	Ewa	dowdol:	M	aryland	
Baltimore,	permit. F Departm Importa any inju		21. Signature of Funeral Service Licen		<u>   Sta</u>	22	Name and	Address of F	acility Sta	uffer F	une	ral Ho	mes,	P.A. 1and 21702	
			2 n. Part 1. Enter the diase, or com- lock, or head shure. List only of	plication that cause	the death							2011, 1	T	Approximate	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as					one				1	Interval Between Onset and Death	
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	icate be executed physician and st the burial-transit	亨	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as			-						_		
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	ian ar	<u></u>	resulting in death) Last	Due to (or as	a consequ	ence of):									
760	cate be executed physician and s the burial-transi	edical Examiner	•	d									$\bot$		
387	rtifice ling p		IF FEMALE:	00 16											
. Box 68	Attending Physician: The law requires that the death certific videath.  **rode Atter this certificate has been signed by the ettending by the funeral director, page 2 should be detached for use e	Physician/N	23b. Was decedent pregnant in the past 12 months?  1										y Day Year		
P.O	es that the signed by	ρ	Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the u	nderlying cau	ise given in I	Part I.					cause of death?	
ğ	requir been should	ete								1					
Reco	n: The law icate has n, page 2 :	Completed	05 W		_					1 🗌 Yes		prior deat	to com	sy findings available pletion of cause of	
/ita	siciar certii irecto	Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:	. 🗀			Other:	Death (Check						
<u>~</u>	Phy r this eral d	은 음	27. Manner of Death	1 ☐ Inpati 28a. Date of inju		ER/Outpatien 28b. Time of		4 L Injury at		me 5 🖾 Resid 28d. Describe h			pecify)		
Ē	tth. : Afte e fun	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Da	y, Year)	injury	м	work?	1	ou. Describe i	iow inju	ry occurred			
.≥	声를	Certificate:	3 Suicide 6 Could not be 4 Homicide determined		ury - At hor c. (Specify)	me, farm, stre				28f. Location (S City or Tow			Rural R	Route Number,	
	Hospital 24 hours Funeral I	Medical	(Check 2 ☐ Medical Exam	sician: To the best of iner: On the basis of e se Practitioner: To th	xamination	and/or investi	gation, in my	opinion, dear	th occurred at	the time, date a	and place	e, and due to	the caus	e(s) and manner stated.	
	To the within 2 To the Comple		29b. Signature and title of certifier					icense numb		,		ate signed (M			
			1 X/ A.Z.H	EGAZO	WI	)		Dr	+41	641	1	1-1	9+	-12	
	$\wedge$		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type, P	int)	rive	Free	Je mil	7	MD	21	702	
	Stat Registra		31. Date filed (Month, Day, Year)  NOV 2 6 2012  32. Fegistrar's Signature  A space												

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health State Registraramend #5 per FH FCHD LE 11/2 **Sertificate** of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 GEORGIA IRENE SMITH November 5:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 10657 Daysville Rd. Walkersville If Under 1 Year If Under 24 Hrs. Social Security Number 220-01-2016 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 1 M 2 X F 97 Nov. 20, 1914 itam 27 is marked other then "natural", or itams 23a or 28e-f shov other treumatic event, the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filad within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10657 Daysville Rd. 21793 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filad within 72 th and Mantal Hygiane. Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roy Wilson Speak Ethel Maude Winpigler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Departmant of Health ar Importent: If Itam 27 is any injury or othar treu John Speak/nephew 11063 Haughs Church Rd., Detour, MD 21757 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Mem. Gar. 11/21/2012 | Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 40 Fulton Ave., Walkersville, MD 21793 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADENOCARCINOMA OF THE COLON Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death.
To the Funeral Director: Affer this cartificate has been signed by the attending physicien and completely filled in by tha funeral director, page 2 should be deteched for use as the burlansit and Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an periormed? Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှု 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? injury 5 Pending Investigation 6 Could not be ☐ Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death page of the cause (s). Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 131761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 W, SENEMPH ST. FREDERICK MD 21701 O'CONNOR MO BRIAN M. 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

Maryland 21215-0036

Baltimore,

68760

Division of Vital Records,

backe

32. Registrar's Signature

6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ November 20, 2012 6:47 A.M. SINGLE MARILYN ELAINE Medical 4a. Facility Name (if not institution, give street and number)
105 Lelia Court 4b. City, Town, or Location of Death Examiner 4c. County Charles Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign **Director** 306-68-0943 1 M 2 X F 55 April 15,1957 Ohio 28a-f show at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No Maryland Charles La Plata 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 105 Lelia Court 20646 <u>United States</u> 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō ò 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Completed 3 Widowed 4X Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ traumatic James Richard Shanks ge 1 and 2 should be nt of Health and Men :: If item 27 is marke Marilyn Jean Steel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth J. Single/Daughter 105 Lelia Court La Plata, Maryland 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State injury or Department Important: I Peter & Paul Cem 11-26-2012 | Windber, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Arehart-Echols F.H. 211 St.Mary.s Ave.La Plata,Md. varyton M00174 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 08 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 ass IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 Live Birth
4 Pregnant a
9 Unknown Month Day Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available 24a. Was an page 2 autopu, performe prior to completion of cause of death? safter death.

I Director: After this certificate! 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 8:46 LAWRENCE MICHAEL STEPIEN november 48, 2012  $\mathbf{A}_{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES RESIDENCE. 7 ELDER PLACE INDIAN HEAD Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Hours AUCUST 11, Year 1948 095-42-6137 NEW YORK 64 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MARYLAND CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 ELDER PLACE 20640 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Arroed Forces Black, White, etc. 1 Never Married 2 Married þ <sup>2</sup> NPERSIAN Baltimore, Maryland 21215-0036 If Yes, Give
Year or Dates—GULF WAR 1 ☐ Yes 2 👿 No Specify: Specify: WHITE 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " College (1-4 or 5+)
YEARS Elementary/Seconday (0-12) MECHANIC FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CHESTER STEPIEN CARMELINE GATT STEPIEN permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is mark any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA SANNA / DAUGHTER 7 ELDER PLACE, INDIAN HEAD, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VEITRANS CEMEITRY NOVEMBER 28,2012 CHELTENHAM, MARYLAND Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CORONARY ARTERY DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) requires that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC KIDNEY DISEASE Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an **HYPERTENSION** autopsy performed? Yes 2**X** No death?
1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A' completed filled in by the ft Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) , MD MD037120 12012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEATHER N. DEVICK, M.D., VAMC, 50 IRVING ST. NW, WASHINGTON, DC 20422/688 Registrar's Signatur NOV 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROBERT L. STEHLING Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 54450411 HICOMICO KEGIONAL 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 8. Date of Birth Days Hours Min (Month, Day, Year) 11-18-1933 Director 214-30-7457 79 1 X M 2 □ F MARYLAND 2 should be filed within 72 hours efter deeth with the Merylend ith end Mentel Hyglene.
27 is merked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DELAWARE SUSSEX FRANKFORD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34699 BETHANY DRIVE 19945 US 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Year or Dates. 51-55 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 🗆 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) COUNTY PSYCHIATRIC College (1-4 or 5+) 5+ Elementary/Secondary (0-12) SERVICES SOCIAL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VERNON STEHLING LOUISE HINKEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth eltern 27 I MARY F. STEHLING/ SPOUSE 34699 BETHANY DR, FRANKFORD, DE. 19945 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Pege 1 ¢
Depertment of F
Importent: If its
eny injury or oti 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Commation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MELSON'S CREMATORY 11-23-2012 FRANKFORD, DELAWARE 21. Signature of Fu Melson funeral ityservices ltd 38040 MUDDY NECK RD, OCÉAN VIEW, DE. 19970 23a. Part 1. Enter the shock, or hear disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause inal Physician/ disease or condition Due to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physicien end I for use es the buriel-trensit Exam deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown 5 Other (specify) Month Day cete hes been signed by the ( ; pege 2 should be deteched To the Hospitel or Attending Physicien: The lew requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completaly filled in by the funeral director, page 2 should be detechn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 41 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes ည 1 🖔 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1X Natural 1 🗌 Yes 2 No Investigation Accident ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H8 MG 829 MD

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

6

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 1 - State Registrar 26, tchd, 11/14/12, r1s Certificate of Death Amended# 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 11, 2012 BARBARA A. SWITZER 2:25 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TALBOT EASTON TALBOT HOSPICE HOUSE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Director 72 706-07-5341 1 □ M 2 🗶 F Yrs. AUG. 18, 1940 WASHINGTON, DC Usual Residence of Decedent 28a-f show 10b. County ir then "neturel", or items 23e or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD TALBOT EASTON 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29790 LYONS DRIVE 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 🌠 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then 'eny Injury or other treumatic event, the Me CENTRAL Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT 12 INTELLIGENCE AGENCY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည THEDA DARWELL PAUL SCHOOLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29790 LYONS DRIVE, EASTON, MD 21601 PHILIP C. SWITZER, HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) STEVENSVILLE, MD CHESAPEAKE CREMATION: 11/13/2012 21. Signature of Pupperal Service L DELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 4200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disesse, or complications half aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician end s the burlal-transit Exam death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending physical for use es the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year signed by the a ld be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform 2X No Yes 2 1 Tes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Other: 4 □ Nursing Home 5 Sesidence 6 K Other (Specify) Hospice မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Director: A d in by the f Investigation 3 Suicide
4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or At 24 hours after of To the Hospital or A within 24 hours after To the Funerel Direc completely filled in by Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID H. RSIZ SMITH, MD 8221 TEAL DRIVE, STE. 301, EASTON, MD 32. Registrar's Signature **1** 4 2012 Registrar

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar Certificate of Death	Reg. No.	4 4044
Physician/ Medical Examiner		Date of Death     Month Day Year     November 10, 2012	3. Time of Death 0411 hrs
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Easton Memorial Hospital  Easton	4c. County of De	ath
Funeral Director	5. Social Security Number 177-46-1953 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9.	Birthplace (State or eign Country) GERMANY
nd thow any cc.	Usual Residence of Decedent  10a. State		10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 23a-f show notified at once. al Director	10e. Street and Number 29070 SUPERIOR CIRCLE 21601	10g. Citizen of What C	ountry?
fter death with 1°, or items 23 ter must be 10 y Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Named Forces? 1 Never Married 2 No 3 Widowed 4 Divorced If Yes, Give Year  1 Yes, Give Year  1 Yes 2 No 1 Yes 2 No specify:		erican Indian, Black, WHITE
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  15. Decedent's Education (Specify only highest grade completed)  College (1-4 or 5+)  12  16a. Decedent's Usual Occupation (Give kind of we during most of working life. DO NOT use retired to the proof of the pr	ed)	SAFETY
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	17. Father's Name (First, Middle, Last)  18. Mother's Name (DONALD SCHNARS)  INGE	(First, Middle, Maiden Surname)	, , , =
MD 21 ad 2 should alth and Me 27 is ma 27 is ma anuatic en	19a. Informant's Name/Relationship (Type, Print)  KELLY J. SCHNARS, WIFE  29070 SUPERIOR CIRC	LE, EASTON, MD	ate, Zip Code) 21601
Baltimore, Dermit. Pages I an Department of Hea Important: If iter		Date         20c. Location - City           15/12         STEVENSV	,
Physician	21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN 200 SOUTH HARRISON  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	& NEWNAM FUNERA STREET, EASTON, N respiratory arrest, shock, or heart	L HOME, P.A. D 21601  Approximate Interval
/Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):		Between Onset and Death
led nsit <b>Examiner</b>	Sequentially list conditions, if any, leading to immediate cause First Underlying Cause (Disease or injury that initiated		
vecuted 1 and 2 transit	events resulting in death) Last Due to (or as a consequence of):  d.		
certific	UNPENDED  AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AMENDED  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown	23d. Date of deliv	ery Day Year
P.O. ss that the gned by e detach	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute  1 Yes 2 No 3 P	returns.
I Records, P.O. Box  II. The law requires that the death  Intificate has been signed by the atte  or, page 2 should be detached for ur			
n of Vita ling Physicia After this cer funeral direct on: To Be		nly one)  Home 5 Residence 6 Oth  28d. Describe how injury occurred	ner:
<u></u>	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or l or Town, State)	
To the Hos within 24 h To the Fur completely	29a. Certifier (Check only 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et and manner stated.  29b. Signature and title of certifier  29c. License number	the time, date and place, and due to	the cause(s)
	O.C.M.E.  30. Name and address of person who completed cause of death (Item 23a)	29d. Date signed (A. November 10,	
S U+1VA State	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	ore, MD 21223	
Registrar	31. Date filed (Month 04 7473 2012 32. Registrar's Signature S. Jacks	OGME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vollember Le. 2012 0700 M Snyder Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Funeral 7. Age (In yrs. last birthday) Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 215-20-8793 Director 1 🗆 M 2 🖾 F 94 Nov. 3. 1918 Virginia Usual Residence of Decedent of Health end Mental Hyglene. Item 27 is marked other then "naturel", or items 23e or 28e-f show other treumetic event, the Medical Evansinar must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1304 Pennsylvania Avenue 21742 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖸 No Specify: If Yes, Give 3 ☐ Widowed 4 🖾 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Caregiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h end Mental F 7 is marked of ည Ollie Pearl Davis Guy Hoch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health e tent: If item 27 li Andrea Clopper / Daughter 19 Loose Lane, Hagerstown, Maryland 21742 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Importent: If it eny injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 4 Donation 5 Other (Specify) 11/30/12 Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signatu of Funeral Se 🖊 1601 Pennsylvania Avenue, Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do menter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final MYOCARDIA Physician/ disease or condition resulting in death) DAYS Medical Due to (or as a consequence of) <sup>'</sup>Examiner PHEUMONIA 3 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) signed by the ettending physiclen end d be detached for use es the burial-transit The lew requires that the death certificate be executed CARDIOVASCULAR ATHOROSGE ROTGE that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completely filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? After this certificate 1 Yes 2 No ☐ Yes • Hospital or Attending Physicien: 24 hours after death. • Funerel Director: After this certifica 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 욘 1 Yes 2 No 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 Yes 2 No 5 Pending after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TW-2 6 HMZAZA (ht (M) (W AUNA ROM) 1190 HAL ON TONN 31. Date filed (Month, Day 32. Redistrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	partment of Health and Nertificate of Death	Mental Hygie	ne 2012	1,0222
			Registrar  1. Decedent's Name (First, Middle, Last)	erincate or Death	Reg. 2. Date of Death	No. 4 0 1 4	3. Time of Death
	Physicia Medi		Edgar Jackson Swisher, Jr.			$\overset{\text{Day}}{17}$ , $2\overset{\text{Year}}{012}$	7:45 A <sup>M</sup>
	Examir		4a. Facility Name (if not institution, give street and number) 17400 Central Ave.	4b. City, Town, or Location of Death Mitchellville		4c. County of Death Prince Geo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthd</i> : 217-32-3234 1 X M 2 D F 76 yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth Cou	nplace (State or Foreign ntry)
			217−32−3234   1X□ M 2 □ F   76 <sub>Yrs</sub> Usual Residence of Decedent		Oct. 1, 1	1936 N. (	Carolina
	/land f sho	후	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits
	e Mar r 28a notifii	Director	MD Prince George's Mitchell  10e. Street and Number				1 Yes 2 X No
	s 23a o	Funeral	17400 Central Ave.	10f. Zip Code 20716		. Citizen of What Cou USA	intry?
36	s I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show r other traumatic event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates. 1954–61	3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: What	etc.
21215-0036	hours natura ical E	lete	15. Decedent's Education 16a, De	cedent's Usual Occupation	166	b. Kind of Business/li	
215	in 72 e. nan "r Med	Jmc	(Specify only highest grade completed) (G	ve kind of work done during most of work DO NOT use retired)	ing	o. Kind of Business/ii	ldustry
	d with ygien her th	Be Co	12Te.	legraph Technician		ATT	
Maryland	be filed antal H ked ot c even	To B	17. Father's Name (First, Middle, Last) Edgar Jackson Swisher, Sr.		e (First, Middle, Maid Emmons Ke	,	
aryl	nould I nd Me s marl			ailing Address (Street and Number or Rura			Code
	d2sh altha 27is ertrau		100.11	00 Central Ave., M			
Baltimore,	e 1 an of He If item ir othe		20a. Method of Disposition 1	sposition (Name of rematory or other place)	Date 20c	. Location - City or T	own, State
tim	: Page tment tant:   jury o		4 □ Donation 5 □ Other (Specify) Lakemon	Mem. Gards. 11/2		Davidsonv	ille, MD
Bali	permit. Page 1 Department of Important: If i any injury or conce.		21. Signature of Frieral Service Licensee	22. Name and Address of Facility 5512 NW Crain Hwy.,	Beall Fune Bowie,		5
į	Physician/ Medical		23a. Fart 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac of			Approximate Interval Between Onset and Death 5 - 6 - 1 - 1
	Examiner	L		en system fo			2-3 day 5
	ted Insit	Examiner	If any, leading to immediate Due to (or as a consequence of):	m			2-3 years
	ate be executed physician and the burial-transit	al Ex	Cause (Disease or injury that initiated events resulting in death) Last	Bilateral Cercbi	al Marcul	las Assula	
760	cate b physic	edical	d. prattifie	State a Cercui	at valua	THE THE TOP	201
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1  ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 1 ☐ Pregnant at time of death 1 ☐ Unknown	B		23d. Date of deliv	rery Day Year
, P.O.	es that th signed by I be detac		Part II. Other significant conditions contributing to death but not resulting in the		V	to use contribute to t	
ords	requii been should	letec	Spartic Quadriplegia fro Vascular Dementia	3.11.46	24a. Was an		bably 4 Unknown
Division of Vital Records,	The law ate has page 2:	Completed by	Gastroparesis		autopsy performed	prior to co	mpletion of cause of
alF	sician: The certificate irector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		No 1 ☐ Yes	2 ∐ No
ΖĬ	hysic his ce al direc	임	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	ient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐ Other (Specif	0
י סל	ling P ). After ti funera	ate:	27. Manner of Death  1 Natural 5 □ Pending  28a. Date of injury (Month, Day, Year)  28b. Time (Month, Day, Year)	work?	28d. Describe how inj	jury occurred	
sior	death death stor: / y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be  28e. Place of Injury - At home, farm,	M 1 Yes 2 No	000 1 11 101 - 1		18
Σį	al or A s after I Direct	Cer	4 Homicide determined building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta		Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, dear	estigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the ca	use(s) and manner stated.
	o the vithin 2 o the omple	Š	only one) 3 Certifying Nurse Practitioner: To the best of my knowled 29b. Signature and title of certifier	ge, death occurred at the time, date and pla 29c. License number		use(s) and manner as  Date signed (Month,	
	FSFÖ		* HAUPT IND	D 0033654	I	Date signed (IVIONIII),	
	5 × W		20 Name and address of Area will complete Vision of Joseph (Ivan 00a) (Trans				21407
	Stat Registra		31. Date filed (Month, Day, Year)  NOV 2 0 2012  2. Registrar's Signature		UI., CIC	VOTES VIETE	11.0
	J		Months In Man				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:30PM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 330 BENFIELD ROAD ANNE ARUNDEL SEVERNA PARK 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Min. Hours (Month, Day, Year) Director 214-24-5189 1 🔀 M 2 🗆 F 84 11/20/1927 MARYLAND Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ANNE ARUNDEL MARYLAND SEVERNA PARK 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 330 BENFIELD ROAD 21146 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates. 1946 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 SECURITY MANAGER SECURITY Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ottany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES JOSEPH SPATH, SR. GRAYCE JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GALE SPATH, WIFE 330 BENFIELD RD., SEVERNA PARK, MARYLAND 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
CHESABEAKE CREMATION 1 Burial 2 X Cremation 3 Removal from State 11/21/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lensee 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS FUNERAL CARE HELFENBEIN 814 BESTGA NEWNAM CREMATION RD ANNAPOLIS MI . ₩ ₩ 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) m Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Day Pregnant at time of death 5 Other (specify) Month g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completely filled in by the funeral director, page 2 s autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Hersh 31. Date filed (Month, Day, Year) NOV 2 0 2012 State 32. Aegistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November LEILA BENTLEY SALLY АМ Medical 1:30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 421-12-4342 Months Days Hours (Month, Day, Year) Director 1 □ M 2 **K**X 90 Yrs. 07/02/1922 Alabama Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Prince George's Ft. Washington 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6913 Eagleton Lane 20744 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. ⋧ 1 Never Married 2 Married Maryland 21215-0036 3 Nidowed 4 Divorced If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Completed White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Reserve Officers College (1-4 or 5+) Administrative Assistant Association other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willis Bentley Louise Gav1e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sally / Daughter Muirfield Dr. Upper Marlboro, MD 20772 Baltimore, 20a. Method of Disposition Unk. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date KX Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. Arlington, Virginia Signature of Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) estive Pars Medical (or as a consequence of): Examiner Pars Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 No 1 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011 (Check

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6810

29d. Date signed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 215 PM Nov Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Sama tho south Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreigh Days Months Hours Min. Country) 10/31/1941 Director 1 X M 2 □ F 214-38-1003 71 MARYLAND al Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 X No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21401 2000 B REIDSVILLE STREET UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married 1 X Yes 2 □ No 21215-0036 It Yes, Give ARMY 1969 Year or Dates. 1 ☐ Yes 2 X No Specify. If Yes. Give 3 Divorced 4 Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SALESMAN 12 INSURANCE be filed Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed rtment of Health and Mental H rtant: If item 27 is marked ot njury or other traumatic ever ည ROBERT VIRGIL SMITH, SR. SARAH RANDALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY REID / SISTER 6520 WALTHER AVE. B3 BALTIMORE, MARYLAND 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o CHESAPEAKE CREMATION 1 Durial 2 X Cremation 3 Removal from State 11/30/12 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS, HELFENBEIN, & NEWNAM CREMATION & FUNERAL CARE 314 BESTGATE RD, ANNAPOLIS, MD 21401 Signature of Funeral Service License HELFENBEIN, 224 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) marbid Medical Due to (or as a consequence of) Examiner iabete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ettending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed oerse that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month ed by the e detached i g Unkno Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed , page 2 should be de \$ 1 🗆 Yes 2 🗆 No 3 🗆 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗌 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 Yes 1 Inpatient FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death, To the Funeral Director: After this Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my policies, death 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOV 22 30. Name and address of person who completed dauge of death (Item 23a) (Type, Print) Jati 31. Date filed (Month, Day, Year) NOV 2 6 2012 21211 egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 18, 2012 12:06 Pm Ann Francis Sernatinger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-28-0550 Director 1 M 2 XF 81 Maryland 6/4/1931 Usual Residence of Decedent 28a-f show e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21403 USA 660 Americana Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3<sup>★</sup> Widowed 4 □ Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Homemaker Own Home 2 should be filed with and Mental Hygien 7 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Josephine Vanyo John Joseph Skislak traumatic permit. Page 1 and 2 si Department of Health an Important: If item 27 is m any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Lida Drive, Essex Junction, VT 05452 Jean Harry - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 11/20/2012 Baltimore, MD Baltimore Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Moder T. Wholes 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final troke Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performe 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No ☐ Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Box 68760 P.O. Records, Division of Vital

To the Hospital or Attending Physician: The I within 24 hours after death. within 24 hours after death.

To the Funeral Director: After filled in by the Medical Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier na Name and address of use of death (Item 23a) (Type, Pri Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last)

Jerry Clifford Signor 2 Date of Death 3. Time of Death November 1, 2012 Physician/ 5:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll County 3838 Dakota Road Hampstead If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Feb. 24, **Funeral** 9. Birthplace (State or Foreign 077-34-4783 Days Hours New York 66 1 M 2 □ F Director 1946 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland 28a-f Carroll County Hampstead 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code "natural", or items 23a or 10g. Citizen of What Country? 3838 Dakota Road Funeral 21074 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc ò 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) shipping specialist electronics Be 17. Father's Name (First, Middle, Last)

J. Clifford Signor, Jr. 18. Mother's Name (First, Middle, Maiden Surname) Thelma Eloise Bowerman permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Signor / wife 3838 Dakota Road Hampstead, Maryland 21074 Date 14, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State carroll Cremation 2012 Hampstead, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens Eline Funeral Home 22. Name and Address of Facility M01072 934 South Main Street Hampstead, Maryland 21074 un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Physician/ MEMSHALL Cholawaio CARCHOMA disease or condition 3 MENINS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Dile to (or as a consequence of if any leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending pd be detached for use as IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 2 Accident
3 Spic 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of cer D31660 11/13/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIL 1 HOMAS 10 M am. 291 STONER AVENUE WES THINSTER MANUELLE

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Mont)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Sandra 2012 Summers 8:00 P M Kav November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Golden Living Center Frederick
If Under 1 Year I If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours (Month, Day, Year) 214-36-0550 Director 1 M 2 XF 74 May 2, 1938 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglens. Important: If Item 27 is marked other than "natural", or Items 23 or 28a-f show any injury or other treumatic event, the Medical Examiner research once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 United States 516 Lee Place 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. by F 1 X Never Married 2 Married ☐ Yes 2 🔯 No Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Optical Office Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Mabel Keech Victor Summers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2322 Dotie Trail, Spicewood, Texas 78669 Mark Summers/ Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery 11/28/2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home MO1646 106 E. Church St., Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACCIDENT Immediate Cause (Final CENEBROUPS CULAR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): <sup>'</sup>Examiner HEmi DANESK Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Dusi to for as a ponsey ience of DYSPITAGIA To the Hospital or Attending Physician: The law requires that tha death cartificate be exacuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely fillad in by the funeral director, page 2 should be detached for use as the burial-traneit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 힏 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 \*\*Dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47951

B

State Registrar 814 Toll House Ave . Frederick

MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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A-KAZMI,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 ROGER CLARE SEARS NOV 21 2:48 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 17240 EDWARDS FERRY ROAD MONTGOMERY POOLESVILLE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Director 1 2 M 2 D F 577-46-1910 77 Yrs 04/23/1935 PA Usual Residence of Decedent 27 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Evandhar must be mutified at 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MONTGOMERY POOLESVILLE 1 ☐ Yes 2 ☑ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17240 EDWARDS FERRY ROAD 20837 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 W Yes 2 No1 960 - If Yes, Give 1 962 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. Is marked other than "naturel", or 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates. 1962 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DENTISTRY DENTIST 5+Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ CLARE E. SEARS permit. Page 1 and 2 should be Depertment of Heelth and Mem Important: If item 27 is marke any Injury or other traumatic o ERNA KOONS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20837 19a. Informant's Name/Relationship (Type, Print) MARY SEARS / SPOUSE POOLESVILLE, 17240 EDWARDS FERRY RD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 11/26/2012 BARNESVILLE, MD ST. MARY'S 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Melanoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 □ No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. erel Director: After this certificete has been signed filled in by the funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Hyper Ension 1 Yes 2 No 3 Probably 4 Unknown Hypercholesterolemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? P Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) H61505

State Registrar DHMH 17 Rev 06-2011

DY

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

19710 Fisher Ave, Suik J, Poolesville MD 20837

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D.O.

Amor Duggirala

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

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Franklin Howard Sweeny, Jr	State of Maryland / Department of Health and Me

		1- For State Certificate of Death	Reg	No.	2 4023						
Physicia Medical Exami		1. Decedent's Name (First, Middle,Lest) Franklin Howard Sweeney, Jr.	Date of Death     Month     November	Day Year	3. Time of Death 2012 hrs						
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death							
Funcial		Prince George's Hospital  Cheverly  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 24Hrs	O Date of Birth	Prince George (MM/DD/YYYY) 9. Birt							
Funeral Director		219-88-1832 1X M 2 F 40 Yrs. Months Days Hours Min	_	Foreig	Annapolis, intry)Maryland						
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
land f show once.	ō	Maryland Prince George's Riverdale			1 X Yes 2 No						
e Mary or 28a-	Director	10e. Street and Number 10f. Zip Code 20737	10g	. Citizen of What Coun	try?						
with the		6312 63rd Avenue 20737  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14. Marital Status)	pecify Yes or No-	USA 14. Race - Americ	can Indian Black						
Baltimore, MD 21215-0036 sermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho njury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	Armed Forces?    Married   Armed Forces?   1		White, etc.	ite						
hours fratur		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use ret		6b. Kind of Business/Ir	ndustry						
)36 thin 72 re. than '	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  4  Brakeman		Commercial	Railroad						
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, MD 21215-0036 and 2 should be filed within 7 teath and Mental Hygiene. tem 27 is marked other than traumatic event, the <u>Medical</u>		Antoinette A. Sweeney / Mother   6312 63rd Avenue, Ri			Zip Code)						
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Metropolitan Crematory 11/	20/2012	Alexandria	, Virginia						
Bal permit Depar Impor		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Gasch's Funeral Hor	70 P A H	739 Baltim	ore Avenue						
Physician		23a. Pagl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.			Approximate Interval Between Onset and						
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		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b									
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Division of Vital Records, ptal or Attending Physician: The law require ours after death.  reral Director: After this certificate has been si filled in by the funeral director, page 2 should b	Certification:	1 Natural 5 Pending Nov 14, 2012 1916 hrs 1 Yes 2 ✔ No	28d. Describe how Subject shot b								
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Divis To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at									
To Signature	Me	and manner stated.  29b. Signature and title of certifier  29c. License number	2	9d. Date signed (Mon	th, Day, Year)						
4613		O.C.M.E.		November 15, 20	12						
5 5M		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, B</li> </ol>	Baltimore, MD	21223							
	ate	31. Date filed (Month, 29, 82012 \$2. Registrar's Significant for the second sec									
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مدرد	<i>'</i>	М	Shady Grove 1  5. Social Security Number 6. 8		a (In ure la	st birthday)	If Under 1 Year	Rockvil I If Under 24 I			Montgo	mery uplace (State or Foreign
	Funeral Director			. M 2 □ F	50	Yrs.	Months Days		fin. (Month, De	ay, Year)	Cou	ntry)
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ore e	or off		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐		C	emetery, crer	osition (Name of matory or other plac	Dec	Date	20c. Loca	ition - City or T	own, State
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	with com		29b. Signature and title of Certifier	10			29c. Licens		C.	29d. Date s	signed (Month,	Day, Year)
	1514		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type, I	Print)	0114	9	10016	MEN	19,2012 D 20850
			maricha mata	s hD 101	110	nole	cular >	r Sui	te 206 1	Lock	ille M	D 20850
	Stat Registra		31. Date filed (Month, Day Year)	2 Registra	ar's Signa	ure da	Red				,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Jessie Parks Shipley 2012 10:05 a <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 26789 Osprey Circle Hebron Wicomico 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Days Hours Min (Month, Day, Year) **Director** 213-12-5458 1 🗆 M 2 😿 F 92 March 1, 1920 Maryland Usual Residence of Deced show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Hebron 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26789 Osprey Circle 21830 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married Yes 2x No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give white Specify: Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) licensed practical nurse 12 health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jesse R. Parks Evelyn Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betsy Jo Shipley daughter 26789 Osprey Circle, Hebron, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Maryland Veterans Cem 11/16/12 4 Donation 5 Donation Other (Specify) Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. KIR 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph si ian vee V disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown P.O. signed by t d be detach Part II. Other signifiqant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 x Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After 28d. Describe how injury occurred ■ Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

3 🗆

16

cause of death (Item 23a) (Type, Print)

S. Division

1346

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

L5000

12-08815 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Leslie Elmer Simering, Sr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Leslie Elmer Simering Sr. Medical Examiner November 19, 2012 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 14350 Drapers Mill Road Greensboro Caroline 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Days Months Hours Min Director 220-14-4083 10/05/1923 1 AM 2 F Yrs Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location f show Maryland Caroline Greensboro be filed within 72 hours after death with the Maryland Director r items 23a nr 28a-f 1ust be notified at 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14350 Drapers Mill Road 21639 IISA Funera 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes 2 No f Yes, Give Year 1946 3 X Widowed Divorced 1 Yes 2 X No specify. Specify:White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. other traumatic event, the Medical MD 21215-0036 12 Mill Wright Mill Work 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Helen Simering item 27 is marked Walter Simering mit. Pages I and 2 should be fill partment of Health and Mental I portant: If item 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Simering 906 Lynvue Rd., Linthicum, MD, 21090 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Date Baltimore, 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Greensboro Cemetery 11/25/2012 Greensboro, MD 4 Donation 5 Other Specify: 22 Name and Address of Facility Fleegle&Helfenbein Fun. Hm. 21. Signature of Funeral Service Licensee 106 W. Sunset Ave, Greensboro, MD, 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a Intracerebellar Hemorrhage complicated by Head Injuries Immediate Cause (Final disease `xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician a the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the the attending pred for use as the 1 Live birth 3 Ectopic pregnancy Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available autopsy certificate has performed? Yes 2 ✔ No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene this FR/Outpatient 3 DOA 1 🗸 Yes ٥ 28a. Date of Injury FOUND: After 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Subject collapsed in garage and hit head Natural FOUND: Pending Yes 2 V No filled in by the Nov 19, 2012 0930 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be

Year

0930 hrs

Foreign Country)Maryland

10d. Inside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Death

Year

2 No

Dav

death? Yes

1

prior to completion of cause of

In the Funeral Director: within 24 hours after Suicide or Town, State) 14350 Drapers Mill Road, Greensboro, MD determined (Specify) Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b/Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E November 21, 2012 Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature

Chamber of

State Registrar 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #1, PER MD G934 State of Maryfand / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ETHEL F. SMITH 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Allegany Medical Cumber land Western Md. Req Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) 212-38-5770 88 Director 1 M 2 X F June 16, 1924 MD Usual Residence of Dec "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🙀 No Mineral WV Ft. Ashby permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be no once. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 26719 Route 2, Box 338 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify 3 🙀 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Sales Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary (Shimer) William Austin Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall Goodwin 1356 Pine View Trail, HOULTIN, WI 54082 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 11/28/12 Frostburg, MD Frostburg Mem Park Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, P.A. John , 1302 National Highway, LaVale, MD 21502 Rat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final Onset and Death Physician) ranac disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ☐ Live Birth 2 ☐ Fetal deat ☐ Pregnant at time of death in the past 12 months? Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medica! Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memoros 32. Redistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year Physician/ 6:35 AM NOVEMBER James Edward Truslow 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ABNES HOSPITAL NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Hours (Month, Day, Year) Director 1 X M 2 □ F 218-32-8781 75Yrs 2/10:/1937 MD Usual Residence of Decede item 27 is marked other then "netural", or items 23a or 28a-f show other treumatic event, the Medical Evaniner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director 1 Yes 2 Tho MD Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21904 27 Staymen Dr 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. 1 🕅 Never Married 2 🗌 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Shoe Manufacturing Shoes Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 permit. Pege 1 and 2 should be Depertment of Health and Ment Importent: If item 27 is marke any injury or other treumatic ( Frank W. Truslow Gavrella Snelling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colora. Robert Truslow/ brother 446 Love Run Rd. MD21917 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Asbury Cemetery 11/27/12 Perryville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
R.T. Foard Funeral Home,
111 S. Queen St. Rising P.A. Queen St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death CLOSTRIDIUM DIFFICILE COLITIS Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of). this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1) EMENTIA 2 🕱 No 3 🗌 Probably 4 🗍 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Tyes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical 8e Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the time of time of time of the time of the time of the time of the time of time of time of time of the time of 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 HAMMONOS BALTIMORE FERRY AWAN

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 23, 2012 Tony Toantrong Tran 7:10A November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 73 Director 220-96-4451 1 🕱 M 2 □ F Dec 14, 1938 Vietnam permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is merked other then "neturel", or items 23e or 28e-f show any Injury or other treumetic event, the Medical Examiner must be notified at 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director Germantown Maryland Montgomery tycxYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20876 USA 20304 Scenery Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 ☐ Never Married 2 🖾 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: 3 Divorced Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Microbiologist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lan Trong Tran Hieu Thi Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20304 Scenery Drive, Germantown, Maryland Kimhuong Tran - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-1-2012 Stauffer Crematory Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute erebrovascular Accid disease or condition Medical resulting in death) Due to (or as a consequence of): Examine Iratory F allure Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physicien: The lew requires thet the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit neumoni that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Advanced Dementa IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 ☐ Other (specify) Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN ours efter death.

erel Director: After this certificate I filled in by the funeral director, pag 1 Yes 2 XNo ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 Yes 2 No Other: 1 Mnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD D74374 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

aya

31. Date filed (Month, Day, Year)

ommineni

6 2012

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

9901

MD

32. Registrar's Signature

Medical Center Drive Rockville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 22 2012 ROBERT WALLACE TINSLEY JR 9:11 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL FREDERICK FREDERICK MEMORIAL FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Hours Days (Month, Day, Year) Director 213-86-8703 1 M 2 T F 50 Nov. 25, 1961 Washington, D.C. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b County 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Monrovia 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21770 3533 Runkles Dr. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ♣ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify: 3 - Widowed 4 Divorced Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Industry Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sarah F. Lawson Robert W. Tinsley, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3533 Runkles Drive, Monrovia, MD 21770 Robert W. Tinsley, Sr., Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State of Heaven Cem 11/27/2012 4 Donation 5 Other (Specify) Gate Silver Spring, Maryland 22. Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, maryland 20872 21. Signatu Art ... Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Pnysician/ 0 apres Medical resulting in death) Due to (or as a consuluence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit cumon1º that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 1 ☐ res ∠ ☐ 9 ☐ Unknown Part II. Oth<mark>er significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 2 🕅 🐪 0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medigal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🚜 🗆 çertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011 29b. Signatur

31. Date filed (Month)

and title of certifier

30. Name and address of person who opmpleted ca

erre

26

barker

400 W. 7th ST. FRE DERICK, M.D.

se of death (Item 23a) (Type, Print)

DAGL

Registrar's Signature

allend.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-State Registrar 17, tchd, 11/13/12, r1s Amended Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 Martha Oglesby 2012 11:55PM Turner Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caroline Caroline Nursing Home Denton If Under 1 Year If Under 24 Hrs.

Manthe Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** 1 🗆 M 2 🕱 016-115-1922 Georgia 221-18-0169 90 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Caroline Md. Denton 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 346 Deep Shore Road death with 21629 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: Black 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward-Sid Oglesby Shellie Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 346 Deep Shore Rd., Denton, Maryland 21629 Edward Oglesby / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11-15-12 Goldsboro, Md. 4 Donation 5 Other (Specify) New Union Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover St., Easton, Maryland 21601 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as the l IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? P Pregnant at time of death 5 Other (specify) Month Day Year After this certificate has been signed by the a funeral director, page 2 should be detached for g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 D Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 (2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 12 Natural injury 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be within 24 hours after des To the Funeral Director completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 14 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 34 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) es 3 32. Registrar's Signature State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	arylar			nt of He te of D		d Me		giené Reg. No.	012	100	39
T			1. Decedent's Name (First, Middle, La	st)						2	Date of Dea	ath Day	Year	3. Time of E	Death
	Physici /Medio		William J. To	bin						N			2012	12:45	a <sup>M</sup>
Y	Examin		4a. Facility Name (If not institution, giv				4b. City	, Town, or	Location of D	Death		4c. C	ounty of Dea	th	
			Keswick Multi-C	are Center	•		В	altim	ore						
	Funeral Director		5. Social Security Number 6. S 223–56–9936	ex 7.Ag X∆M 2□F	e (In yrs. 70	last birthday) Yrs.	II Und	Days	If Under 24 I Hours N	Min.	Date of Birt (Month, Day ay 17	v, Year)	Co	thplace (State or buntry)	Foreign
	p ,		Usual Residence of Decedent  10a. State 10b. County		100 0	Town sele								104 14- 01	. 1 1 - 2 -
	aryla ehov	_	,	<b>.</b> :	10c. Ci	y, Town or Lo								10d. Inside City	
	8a-f	ctc		timore		Tows								1 🗆 Yes	X
	th with the 23a or 2	ai Director	10e. Street and Number 531 Stevenson L	ane				ip Code 286				10g. Citize	on of What Co SA	ountry?	
030	should be filed within 72 hours after death with the Maryland of Menial Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 21a or 28a-f show marked other than "natural be notilled at	by Funeral	11. Marital Status  1★ Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1Yes _ 2X! If Yes, Give Year or Dates:		li li	fYes, sp	edent of His ecify Cubar 2 XNo	spanic Origin' n, Mexican, Pi Specify:	? (Specil uerto Rid	fy Yes or No- can, etc.)		l. Race · Ame Black, Whit Specify:		
0500-6121	within 72 ho ine. ihan "natur in Modical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	i+)		kind of w DO NOT	ork done d use retired)	ition furing most of	working		Joint	t Chie Staff	•	
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land	ntal h	Be	William L. Tobi							- 1	allon	Maidell 3	umanie)		
2	d Mei d Mei nark	2	19a. Informant's Name/Relationship (			10h Mailin	a Addas	o /Ctroot o	nd Number o			City or	Tour State	Zin Codel	
2	d 2 si th and 7 ts r		Michael P. Smit	**			•							MD 2120	14
a)	1 and Heall em 2		20a. Method of Disposition	II, IOA	20b. F					Dat			ation - City or		7-1
altimor	Pages ment of ant: If it ury or o		1 Burial 200 Cremation 3 4 Donation 5 Other (Specif			Place of Disposemetery, crem rroll (				/19/	2012		stead,		
Dail	permit. Pages 1 and 2 should by Departiment of Health and Menia Important: If Item 27 is marked sny Injury or other traumatic a <u>once.</u>		21. Signature of Funeral Service Lices  Youlds  L	Lemmer	M00	741			s of Facility		ne Fun				
gan.			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.	h. Do not ente	er the mo	de of dying	, such as car	rdiac or r				Approximate Interval Betw Onset and D	reen leath
•	Physician /Medical Examiner		disease or condition resulting in death)	a. Sub or Due to (or as	a consec	uence of):	H	Muc	s-hase	<u> </u>				3 month	2
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O. BOX	the death certificate be executed y the ettending physician and Iched for use as the burial-transit	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	ildeath 3□	Ectopic Other (s	oregnancy specify)				23	d. Date of de Month		ear
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ecords,	The law requires that ate has been signed b page 2 should be deta	Completed								-	24a. Was		No 3 P	utopsy findings a	nknown
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VII	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only o				
5	bis by	은	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 U Inpatie		ER/Outpatien		UA	4 Nursir				Other (Spe	icify)	
LOI!	anding P lath. or: After t	ation	1 Natural 5 Pending 2 Accident investigation	1	y Year)	28b. Time of Injury	М	28c. Injury Work 1 ☐ Y	at ? ∕es 2 □ No		d. Describe f	iow injury	occurred		
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined		ury - At h c. <i>(Specil</i>	ome, farm, stre	eet, facto	ry, office		28	f. Location (S City or Tox	Street and vn. State)	Number or A	ural Route Numb	10 <i>f</i> ,
	se Hospi 24 hours se Funer bletely fill	edicai	29a. Certifier 1 Certifying Processing (Check only one) 2 Medical Example 1	ysician: To the best niner: On the basis o and manner st	l examina	owledge, death ition and/or inv	occurre vestigation	d at the tim n, in my op	e, date and p inion, death o	olace, and occurred	d due to the at the time,	cause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)	
	withi To th	ž	29b. Signature and title of certifier				2	c. License	number			29d. Date	signed (Mon	th, Day, Year)	
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	(BC		30. Name and address of person who			n 23a) (Type,	Print)				1				
	7		Dalket Salu	1a Mo		00 W	c\$ €	46+	2 5+	Ba	14 1	760 J	L()(4		
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa		1	<b>W</b>							
	Registr	rar	MHV Z U	7111 A 20 m	. 4.44	13 1	the stands	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Olga Tears Physician/ November 2012 10:10 AM Medical 4a. Facility Name (If not institution, give street and number)
1207 Northbrook Drive 4b. City, Town, or Location of Death 4c. County of Death
Carroll County **Examiner** Hampstead If Under 1 Year If Under 24 Hrs. 7, Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 150-16-7757 Min. (Month, Day, Year) lay 5, 1924 1 □ M 2 🛛 F Months Days Hours Pennsylvania 88 Director May Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Carroll County Maryland Hampstead 1 🗆 Yes 2 🔀 No 28a-f 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code ŏ ed other than "natural", or items 23a or event, the Medical Examiner must be 1207 Northbrook Drive 21074 Funeral United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 **X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. George Thomas Anna Kidora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margie T. Farmer / daughter 1207 Northbrook Drive Hampstead, Maryland 21074 20b. Place of Disposition (Name of cometery, crematory or other place)
Hampstead Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Nov. Date 7 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Hampstead, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street HAmpstead, Maryland 21074 un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) on Medical Due to ( is a consequence of Examiner auseas Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be-thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 11 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 4 Pregnant : 9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation
6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the within To the

State Registrar

29b. Signature and title of

Stephen

31. Date filed (Month, Day, Year) 32. Registrar's Signature MOV 15 201

rtifier

Laiken, M.D.

Hampstead, MD 21074

person who completed cause of death (Item 23a) (Type, Print)

iken, M.D. 1005 South Main Street, Suite A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 14, 2012 8:55 А м Mildred Trice Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caroline Preston 6983 Dawson's Branch Drive Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Delaware 1 □ M 2 👽 F Months Days Hours Min. 6/30/1925 Director 222-12-9693 87 Usual Residence of Decedent show 10b. County 10c. City, Town or Location aţ 10a. State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No Caroline Preston Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 6983 Dawson's Branch Drive 21655 rral", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: white Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Family Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Della Mae Anderson Harry Thomas Steen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9886 Mila Street Denton, Maryland Thomas L. Trice/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Concord Church Cemetery 11/18/2012 Federalsburg, Maryland 21. Signature of Funeral Service Licenty 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South 2nd Street Denton, Maryland 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cancer ancreatic Physician month s disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has I completed filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☑ No Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 AResidence 6  $\square$  Other (Specify) 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🔼 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ပ HOVEMBER 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. WASHINGTON ST, EASTON MD 21601 LAKSHMI VAIDYANATHAN 31. Date filed (Month Registrar's Signature State 1 6 2012 Registrar

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and	Mental Hyg	giene	1 0	1 1 - 0		
			1 - State Certificate of Death		Reg. No.	112	47747		
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  VIVIAU TERRELL	2. Date of Dea Month		Year EO12	3. Time of Death  1930  M		
	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Peat 4lO-D Jilver Leaf, Ct.	ruie	4c. County	of Death			
	Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$		(Year)	Country	ce (State or Foreign ) 1k, Va.		
	yland f show ed at	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			100	I. Inside City Limits		
	e Mar r 28a- notifi	Dire	Maryland Anne Arundel Glen Burnie		10g. Citizen of \	Mhat Caunta	1 X Yes 2 No		
	with th ss 23a o rust be	Funeral Director	410 Silver Leaf Ct. #D 21061		9	d Stat			
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	11. Marital Status  1 ■ Never Married 2 ■ Married  3 ■ Widowed 4 ■ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ■ Yes, Sive Year or Dates.  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl of Yes, Give Year or Dates.	specify Yes or No- to Rican, etc.)	Blad	e - Americar ck, White, etc Black	<b>.</b>		
21215-0036	vithin 72 hou liene. er than "natu the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)  Program Analyst	rking		f Business/Industry			
Maryland 2	be filed v ental Hyg ked othe c event,	To Be	17: Father's Name (First, Middle, Last)  Aaron D. Terrell  Unk.	me (First, Middle, I	Maiden Surname	9)			
ary	hould and Me s mar umati		19a. Informant's Name/Relationship (Type, Print)/ La yanten 19b. Mailing Address (Street and Number or Ru						
Σ,	nd 2 s lealth a m 27 i		LaShonda Terrell Whitehead 3532 Princess Caroli	- 1					
Baltimore,	Page 1 a nent of H ant: If ite ury or otl		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Riverdale Park  11/	Date /23/2012	20c. Location - Riverd	-			
Balt	permit. Departi Import any inji		21. Signature of Funeral Service Lice see 22. Name and Address of Facility  Alexander S. Pop 5538 Mariboro Pi	e. P.A. ke Fores	tville,	Md. 2	0747		
	Physician/		23a. Patr 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause an each line.  Immediate Cause (Final disease or condition resulting in death)  a.	c or respiratory arre	est,	A	pproximate Merval Between Dinset and Death		
Ì	Medical Examiner		Here Linia emin						
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury						
	ate be executed hysician and the burial-transit	dical Exa	that initiated events c.  The property of the						
2092	cate to physical phys	ledic	d				-		
. Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after clearh.  To the Funeral Director: After this certificate has been signed by the attending ploompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant     in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown			te of delivery	ay Year		
ls, P.O.	requires that the des been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	10		cause of death?		
Division of Vital Records,	Physician: The law recrithis certificate has bee aral director, page 2 sho	Completed		24a. Was a autop perfor 1  Yes	rmed?		y findings available bletion of cause of		
/ital	sician certifi irector	o Be	25. Was case referred to medical examiner?  1 X Yes 2 \( \) No   Hospital:  1 \( \) Inpatient 2 \( \) ER/Outpatient 3 \( \) DOA   Other:  4 \( \) Nursing	eck only one)  Home 5 🕮 Kesid	6 🗆 0#-	(0			
of V	ling Phy 1. After this funeral d	ate: To	1 Manner of Death  1 Inpatient 2 ER/Outpatient 3 DOA State of Injury  1 Natural 5 Pending (Month, Day, Year)  2 Accident Investigation  M 1 Yes 2 No	28d. Describe ho					
27. Manner of Death   1									
J	e Hospita 124 hours 9 Funeral letely fille	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, only one)	d at the time, date ar	nd place, and du	e to the caus	e(s) and manner stated.		
	To the within To the comp	2	29b. Signature and title of certifier  Deputy  29c. License number  Dobos	. :	29d. Date signe				
	5TM		30. Name and/address of person who completed cause of death (Item 23a) (Type, Print)	Ame	mich	2	1035		
	Sta Registra		31. Date filed (Month, Day Year)  32. Registrar's Significant factors and Secretary Significant factors and Secretary Significant factors and Secretary Secr	1 1 2	- W- 7 8				
	9								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Mildred Ann Villani 7:20A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Worcester 118 Cedar Avenue Berlin Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) MD **Funeral** Days 1 M 2 X F Months Min 08 220-26-8555 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD. Worcester Berlin 10e Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or Funeral 118 Cedar Avenue 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 ₩ Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) Clerk/Bookkeeper Calvin B. Taylor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Ernest M. Tyndall Mildred Linwood Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9718 Seahawk Road, Berlin, MD. 21811 TAnya B. Cropper-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 11-30-12 Berlin, MD. Buckingham Cem. 22. Name and Address of Facility The Burbage Funeral Home 108 Street, Berlin, MD. 21811 Part 1. Enter the disease, or complications that diused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause or each line.

ediate Cause (Final Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying <u>i</u> Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of ilinjury that initiated events resulting in death) Last the burial-trans and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached fo Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to con death? page 2 autopsy performe certificate 2 1 Tyes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 7 Manner of Death 28b. Time of Certificate: 28c. Injury at work? After <sup>≜</sup> Natural injury 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in much Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the beet of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 within 2 only one 9b Signature and title of 29d. Date signed (Month, Day, Year) D26278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID COWELL, MD. 10776 GRZYS CONVER RD, BESTIN, MD. ZI 311 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Weaver 7:44 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince beonse TAG Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs **Funeral** Hours Director 56-5314 1 ■ M 2 □ F 16 20-1936 Georgia 28a-f show 10b. County 10c. City, Town or Location 10d Inside City Limits must be notified at Director 1 Yes 2 No MARILAND beorge LASCO 0 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral Rd 16701 20608 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc Armed Forces? 1 Never Married 2 Married Yes, Give Page 1 and 2 should be filed within 72 hours after 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DONQT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Flementary/Secondary (0-12) College (1-4 or 5+) leriz 12 lechnician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Ra Arrie 149/e -ASCO other Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, mportant: If injury or 11-29-12 1etropolitan Signature of uneral Service Lic and Address of Facility any MD 206 08 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death be detached the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 W Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

OU

8 2012

Physician/ Harold N. Willett, Sr. Medical **Examiner** 8100 Holiday Ave. 5. Social Security Number **Funeral** 1 X M 2 □ F 214-42-3756 Director Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director Maryland Prince George 10e. Street and Number 8100 Holiday Ave. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 3 Widowed 4 Divorced is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Be 17. Father's Name (First, Middle, Last) ည Aubrey S. Willett 19a. Informant's Name/Relationship (Type, Print) Linda Willett Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 21. Signature of Funeral Servi Physician/ disease or condition resulting in death) Medical **Examiner** Securitally let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trai resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 11:36 p M 2012 November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Prince George If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Hours 68 April 21, 1944 Maryland 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🛣 No Fort Washington 10f. Zip Code 10g. Citizen of What Country? 20744 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2v2 No Specify: Specify: White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Ceramic & Marble Serv. Contractor 18. Mother's Name (First, Middle, Maiden Surname) Mary E. Gamble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 8100 Holiday Ave., Fort Washington, Md. 20744 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Nov. Alexandria, Virginia Metropolitan Funeral Service Williams Fufferal Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Due to (or a a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Pregnant at time of death 9 Unknown Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ပ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

Registrar DHMH 17 Rev 06-2011

To the Hospital within 24 hours a To the Funeral C Hospital

Records,

**Division of Vital** 

page 2 should

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month STIM forembe Medical 4b. Facility Name (if not institution, give street and number) or ocation of Death 4c. County of Death Examiner City, Town (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Director 1 M 2 F Usual Residence of Decedent in and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No 21215-0036 1 Yes 2 LINE If Yes, Give Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>th</u> once. æ Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 51 9802 Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) YG CO 22. Name and Address of Facility Signatur Funeral Service Lic unerd 19805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Patitis that initiated events Due to (dr as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? After this certificate 1 🗌 Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 [J/No ရု 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred - Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direc Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier . License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 00, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month oroth Jovember Medical Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Tow or Location of Death lato g. Birthplac Country) 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) If Under 1 Year Months Hours 42-0660 Director 1 M 2 F -24-Maryland 28a-f shov 10c. City, Town or Location must be notified at Director 1 Yes 2 No Olonia moreland ō 10e. Street and Numbe 10g. Citizen of What Country? Funeral or items 23a 22443 USA 2. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Medical Examiner Black, White, etc. 1 Never Married 2 Married Completed by Yes Yes, Give 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 ☐ Divorced Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit, Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the I any injury or other traumatic event, the I 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ound 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6025 teights 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 12 20608 21. Signature Juneral Service Lice see Name and Address of Facility MI 1 400 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Sever Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of): as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an sate has l autopsy death? performed certificate Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ဂ္ဂ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending work Accident 1 🗌 Yes 2 🗌 No Investigation completely filled in by the 3 Suicide 4 Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 21 Name and address of person who completed cause of death (Item 23a) (Type, Print) State 6 201 Registrar

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State	State of Ma	arylan		partment of H		Mental Hy	giene	2012	2 40248
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he Ma or 28a o notif	Dire	Maryland Charles 10e. Street and Number		M	laldor	10f. Zip Code			10g. Citize	en of What C	1
with t	eral	11080 Weymouth Cour	rt Ant# 2	09		20603			USA		
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le 1 ar t of He If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ሺ Cremation 3 ☐ Re	moval from State	20b. P	lace of Disp emetery, cre	osition (Name of matory or other place	e)	Date	20c. Loc	ation - City o	r Town, State
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify)		Hur		ematory					Maryland
perm Depa Impo any i		21. Signature of Funeral Service Licensee	0.0			22. Name and Addres		luntt Fur en Rd. Wa			20601
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Hospi 24 hou Funer sted fill	Medical		On the basis of ex	amination	and/or inve	stigation, in my opinio	n, death occurred	at the time, date a	nd place, a	nd due to the	cause(s) and manner stated.
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the 24 hours after death.  To the thereal Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Ž	only one) 3 Certifying Nurse F 29b. Signature and title of certifier	ractioner: To the b	est of my	knowledge,	death occurred at the 29c. License				and manner as signed (Mont	
->-0		> uffangereur	CRIADOS			Rizi	4736			19-20	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Lorayne Whitson 5:50p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 64 Hatteras Street Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) N . Y . 1 M 2 DE 2-18-1940 Days Hours Min. 72 Yrs Director 071-32-8055 Usual Residence of Decedent 28a-f show aţ 10a. State 10h County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Examiner must be notified 1 St Yes 2 No MD Worcester Berlin ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 64 Hatteras Street 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give 2 🕅 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 Divorced Specify: White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Man Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Majden Surname) 2 Charles Thielemann Dorothy Wexler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Whitson - Spouse 64 Hatteras Street, Berlin, MD. 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem 11-26-12 Millsboro De. 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William Street, Berlin, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Retroperitonea Medical Due to (or as a consequence of): Examiner Hupertension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir of as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No ō Month Pregnant at time of death Day Year signed by the a 9 Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page certificate 2 🗌 No 1 Yes after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2. No Hospital Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5. Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death-occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2 To the only one) 29c. License number 29d. Date signed (Month, Day, Year) H0066462 11-26-12 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre ROCETRACK RD. Bostin 10514 JUSTERBY SOLHEIR

DHMH 17 Rev 7/2009

State

Registrar

egistrar's Signatur

26

2012

12-09058	
Machina Wilson	

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Certificate of Death

		Registrar		Ce	rtificate (	ט ונ	eaur				Reg. No.			
Physicia ledical Exami		Decedent's Name (First, Middle     Machina Ann Wi	_						2	Date of De Month Novembe	Dav	Year 2012		3. Time of Death 0303 hrs
		4a. Facility Name (if not institution Peninsula Regional Me		mber)			ty, Town, or Lo Hisbury	ocation of	Death	,		County of Nicomic		
Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	lf L	Under 1 Year	If Under	24Hrs.	1			9. Birth	place (State or
Director		214-76-1984 Usual Residence of Decedent	1M 2XF	41	Y	rs.	Unitins Days	Flours	IVIIII.	09-09	9–19	71		ntry) MD
v any		10a. State 10b. County		10c. City	, Town or Loc	ation								10d. Inside City Limits
Maryland 28a-f shnw 1 at once.	ţ	MD Worces	ter:	Poc	omoke (						10 00	(1)40		1 Y Yes 2 No
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h with t ems 23a	Funeral	11. Marital Status  1 Never Married 2 X Ma	12. Was Dece	edent Ever in U						pecify Yes or No- 14. Race - Amer				an Indian, Black,
her deat			1 Yes	2X No		_	2 X No			,		Specify:		ite
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36 in 72 h is tan "p	Completed	Elementary/Secondary (0-12)	College (1-	-4 or 5+)	Homema		-	001010	130 101110	u,	D.	omest:	io	
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	a	Harry Truitt								onaway				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", nr items 23a or 28a-f shi injury or other traumatite event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationsh Charles Wilson		and	1.0		ress (Street a							Zip Code) ), 21851
Baltimore, MD pernit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati	1	20a. Method of Disposition  1 Burial 2 Cremation	3 Removal fro	om State	Place of Disp crematory or	osition ( other pla	(Name of ceme ace)	etery,	12/	Date	20c.	Location -	City or T	own, State
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Bal permi Depar Impo	-	21 Signature of Funeral Service L	De	moil	2/1/10	Name : )7	ine St	i i domity	HOT.	TOway	rune	erar i	TOLLE	F.Fi.
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18760, tificate be ex ing physician as the burial		IF FEMALE; 23b. Was decedent pregnant in the past 12 months?	e 23c. If yes, c	outcome of preg irth	_	Fetal de	ath 3	Ectopic	pregnan	су	23	d. Date of o	delivery D	ay Year
that the death certified by the attending detached for use as 1	Physicia		4 Pregna	ant at time of d	eath 5	Other (	Specify)				ļ			
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n of ding Ph	on: To	27. Manner of Death	28a. Date of (Month,	of Injury Day,Year)	28b. Time o	f Injury	28c. Injury	at Work?	? 2	28d. Describe			d	
Division In or Attendi rs after death. In Director: A	icati	2 Accident Invest	tigation 28e Place	e of Injury - At I	nome, farm, st	reet, fac		s 2		28f. Location	(Street a	and Numbe	r or Rur	al Route Number, City
Div pital or ours aft feral Di	Certification:	4 Homicide determ	mined (Specify)							or Town,				
Division of Vital Records, P.O. Box 68760,  To the Enspiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	29a. Certifier 1 CertifyIng Phone) 2 Medical Exam	nysician: To the best	of examination										
E.248	Me	29b. Signature and title of certifier		A.			29c. License			-				th, Day, Year)
		ling					O.C.M	I.E.			Nov	vember :	28, 20	12
		30. Name and address of person v Ling Li, MD Assistar	who completed caus nt Medical Exan			ore St	treet, Baltin	nore, N	/ID 212	23				
St Regist	ate	31. Date filed (Month Der Kear)	4 2012 32. Re	distrar's Signat	ure A. A	back	4							•

		Pleas	se Type or Pri	nt in E	Black In	delible In	k. Ens	ure A	II Copies	Are Leç	gible.	
		For State	State of M	aryland				and N	lental Hygi	ene		
		Registrar  1. Decedent's Name (First, Middle, L	act		Cer	tificate of	Death			g. No. 🤈 🕻	112	40251
Physicia Medic			WILLIAMS						2. Date of Death Nonth		Zo12	1:270M
Examin	er	4a. Facility Name (if not institution, g				4b. City, Town, c					y of Death	tan
Funeral				e (In yrs. Ia	st birthday)	If Under 1 Year		24 Hrs.	8. Date of Birth		shing: 9. Birthp	lace (State or Foreign
Director		094-52-9345 Usual Residence of Decedent	1 □ M 2 🛣 F	54	Yrs.	Months Days	Hours	Min.	(Month, Day, ) 07-24-	1958	West	Islip, NY
rland f show	tor	10a. State 10b. County	·	10c. City	, Town or Loc	cation					10	Od. Inside City Limits
Mary 28a-1 otifie	Funeral Director	MD Washi	ngton	Ha	agerst	_						1 Yes 2x No
vith the	ral	10e. Street and Number			2	10f. Zip Code 21742			10	og. Citizen of U.S.		try?
eath v tems	Fune	12820 Little Ell 11. Marital Status	12. Was Decedent B	Apt. Ver in U.S.		Vas Decedent of F Yes, specify Cub	lispanic Or	igin? (Spe	cify Yes or No-	14. Rad	ce - America	
after d al", or i xamin	by	1 ☐ Never Married 2x ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No		Yes 2 No			rican, etc.)	Bla Specify	ck, White, e	<sub>tc.</sub> ack
hours natura dical E	lete	15. Decedent's			16a. Deced	ent's Usual Occup	oation		1	6b. Kind of E	Business/Ind	lustry
vithin 72 jiene. er than " the Med	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4 or 5	i+)		rind of work done D NOT use retired, <b>k</b> .		it of worki	ng	Culi	nary	
be filed vental Hygked othe	To Be	17. Father's Name (First, Middle, Las Howard Fish					18. Moth		e (First, Middle, Ma		re)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship John Williams		ıd	19b. Mailin 1282	g Address (Street O Little	and Numb E11i	er or Rura	d Route Number, (Dr., Hage	City or Town, S	State, <i>Zip</i> C <b>n</b> MD	21742
ige 1 and nt of Heal t: If item		20a. Method of Disposition  1  Burial 2  Cremation 3		ce	emetery, crem	sition (Name of natory or other pla				0c. Location		
nit. Pa aartme oortan injury		4 Donation 5 Other (Special Special Sp		Ar		11e Ceme				Amityv E. Wil		
Depring Imp		/ Latel D Ku	h_		М	innich F	unera	1 Ho	me Hage	rstown	, MD	21740
		23a. Part 1. Enter the disease, or co shock, or heart failure. List only	omplications that caused y one cause on each line	the death	-	1	1	cardiac c	or respiratory arres	t,		Approximate Interval Between Onset and Death
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Anox Due to (or as a	1 C		cephe	1101	Poi	thy			Onset and Doam
Examiner	_	Sequentially list conditions,	b. Ven-	tri	cn(	RY	FI	2	llat	ron		
executed an and urial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a conseque	ence of):	H.	le, v	t	Fail	ure		
@ E : E	_	resulting in death) Last	Due to (or as a		,	Arte	ny	I	) sea	se		
tificate ing phy e as th	Med	IF FEMALE:		,		-						
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director, page 2 should be detached for use as the burian completely filled in by the funeral director, page 2 should be detached for use as the burian completely filled in by the funeral director, page 2 should be detached for use as the burian completely filled in by the funeral director, page 2 should be detached for use as the burian completely filled in by the funeral director, page 2 should be detached for use as the burian completely filled in by the funeral director, page 2 should be detached for use as the burian completely filled in by the funeral director, page 3 should be detached for use as the burian completely filled in by the funeral director, page 3 should be detached for use as the burian completely filled in by the funeral director.	Physician/Medica	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	Ectopic pregnan Other (specify) _	су				ate of delive onth	ry Day Year
hat the ed by detacl	by Ph	Part II. Other significant conditions	s contributing to death b	ut not resu	ılting in the u	nderlying cause g	ven in Part	1.	23e. Did toba	acco use con	tribute to the	e cause of death?
quires en sigr	ted b	Diabetes	5 - 2						1 🗌 Yes	s 2 □ No	3 🗌 Prob	ably 4 Unknown
e law rec has be ge 2 sho	Completed								24a. Was an autopsy perform	ed2	Were autop prior to con death?	sy findings available npletion of cause of
sician: The law I certificate has k director, page 2 s	Be Co	25. Was case referred to medical				26. P	lace of Dea	ath (Check	1 L Yes 2	X No	1 Yes	2 🗌 No
nysicia nis cer I direc	To B	examiner? 1  Yes 2 No	Hospital:	ent 2 🗆 🛭	ER/Outpatien	- loth	er _		me 5 Resider	nce 6 🗆 Oth	ner (Specify)	
nding Pt ath. r: After th	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat	28a. Date of inju (Month, Day		28b. Time of injury	28c. Injur work M 1		.	28d. Describe hov	v injury occur	red	
al or Atte s after de il Directo ed in by th		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine				et, factory, office			28f. Location (Stre City or Town,		per or Rural	Route Number,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of edurse Practitioner: To the	xamination	and/or invest	igation, in my opini	on, death o	ccurred at	the time, date and	place, and du	ue to the cau	se(s) and manner stated.
No the company		29b. Signature and title of certifier	20	n	2	29c. Licens		1 1		d. Date signe		
		Rones	77	111	ິນ ·	1000	69,	6 U 1	5 N ROBUT	ovem	ber,	24,2012
IW-2		30. Name and address of person wh 246 Eastern	Blv Nor		23a) (Type, P # 10	3, Ha	gers	tow	n, M	D	217	40
Stat		31. Date filed (Month, Day, Year)	32. Registra				1			~		

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	e Type or I							_			jible.			
	State of Maryland / Department of Health and Mental Hygiene												10000			
		Registrar  1. Decedent's Name (First, Middle, L	rtificati	tificate of Death				Reg. I	No. /		4025.6					
Physicia	n/	John Garner	[.*							Year	3. Time of Death					
Medic Examin		4a. Facility Name (if not institution, g			4b. City, Town, or Location of Death				Notember 24 2012 8							
Examin		Meritus Medical	Hagerstown				Washington									
Funeral		5. Social Security Number 6	last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.				8. Date of Birth (Month, Day, Year)			9. Birtl	nplace (State or Foreign				
Director	Funeral Director	218-24-0852 1 ⊠ M 2 □ F 79 Usual Residence of Decedent				3.				Aug 20,						
and show		10a. State 10b. County	ty, Town or Lo	ocation								10d. Inside City Limits				
Maryl 28a-f otifie		M <b>a</b> ryland Washi									1 X Yes 2 No					
th the	al D	10e. Street and Number 8 McKeldin Drive					10f. Zip Code					Citizen of	What Cou	untry?		
ath wif	uner	10 Was Danadort Ever in U.C. 113.1					21713  Was Decedent of Hispanic Origin? (Spe					S.A.	Amor	ingo Indian		
or ite	by F	1 Never Married 2 Married 1 Yes 2 No				If Yes, specify Cuban, Mexican, Puerto f				Rican, etc.)		14. Race - American Indian, Black, White, etc.				
ırs aftı ural", I Exal	Completed t	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.					2 🔼 No	Specify:				Specify: White				
"natu		15. Decedent's (Specify only highest	lent's Usual Occupation kind of work done during most of working				ing 16b		6b. Kind of Business/Industry							
ithin 7 ene. r than	Con	Elementary/Secondary (0-12) College (1-4 or 5+)					DO NOT use retired) Tree Surg				geon Ag			griculture		
iled w I Hygi othel	Be	17. Father's Name (First, Middle, Las	t)		<u> </u>			18. Moth	er's Name	e (First, Middle,	Maide	n Su <i>r</i> na <i>m</i>	e)			
d be f denta srked sric ev	10	Reed Olin Weakley					Liza Virgir				0f					
shoull and h is ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	ın <i>d Numb</i> e	er or Rura	al Route Numbe	er, City	or Town, S	State, Zip	Code)		
and 2 lealth em 27 her tr		Bonnie J. Saund	ers/daugh					ve Bo		oro, M						
ge 1 ant of h		20a. Method of Disposition  1 X Burial 2 Cremation 3		tate	Place of Dispo cemetery, cren	natory or o	ther place			Date				Town, State		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)  Beahm's Chapel Cem 11/28/2012 Luray, Virginia  21. Signature of Fundal Service Licensee  22. Name and Address of Facility Bast—Stauffer Funeral Home, P														
permi Depar Impo any ir		I Lako	Ine	and	76	606 0	ld N	atior	al F	ike Boo	rer onsl	rune oro,	MD	21713		
		23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause ontoach line  Approximate Interval Between														
Physician/	Examiner	Immediate Cause (Final disease or condition	ACU	ie iv	ryuca	rde	ex	IN	fur	etra	~			Onset and Death		
Medical Examiner		resulting in death)	Due to (o	as a conseq	uence of):											
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):														
uted d ansit		cause. Enter Underlying Cause (Disease or injury that initiated events														
executed an and urial-trans	I Ex	resulting in death) Last														
cate be executed physician and s the burial-transit	dice	•	d													
eath certifica attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant										23d. Date of delivery				
eath c atten d for u		in the past 12 months?  1  Yes 2 No	Ectopic pregnancy Other (specify)							Month Day Year						
the de by the tachec	hys	9 ☐ Unknown														
requires that the des been signed by the s should be detached	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?						
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sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical					26 PIs	ace of Dea	th (Check	1 Yes	2 🛂		1 🗌 Yes	2 No		
this alo		examiner? 1  Yes 2 No	Hospital:	patient 2 [	ER/Outpatier	nt 3 🗆 D(	Othe	er		me 5 Resid	dence	6 Oth	er (Specia	(v)		
		27. Manner of Death  1 Natural 5 Pending	28b. Time of injury	2	8c. Injury work	at		28d. Describe l								
tendii Jeath. tor: Ai the fu		2 Accident Investigat 3 Suicide 6 Could no		M 1 Yes 2 No												
Il or Attending P after death. Director: After t d in by the funera	Cert	4 Homicide determine	28e. Place o	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and City or Town, State)					nd Number or Rural Route Number, e)			
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ical															
he Ho in 24 I he Fu pletel	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
To t To t		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)												Day, Year)		
	print Drosect H0061117 November											21,2012				
EW-10		30. Name and address of person where the concisco A	Juneal Droces H0061117 November 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Froncisco A Daniel, OD Menitos Medical Cenfer													
Stat		31. Date filed (Month, Day, Year)	2012 32. Re	istrar's Signa	ature	Last	1									
Registra	al C	11010			p. 69	Andrew Co.										

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 40253 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 15 2012 Martha R. Winborne 2001 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arunde1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Funeral 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) (Month, Day, Year, pr 12 1 067-36-9156 Director 1 □ M 2 1 F 70 1942 Pennsylvania 1 end 2 should be filed within 72 hours efter deeth with the Merylend if Health end Mentel Hyglene.
Item 27 is merked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Medical Examinar must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Crofton 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1708 Gaffney Ct. 21114 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** 3 - Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) Service Collections Citibank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Brackett Earlene Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha J. Winborne (Daughter) 1708 Gaffney Ct. Crofton, Md. 21114 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pege 1 depertment of limportant: If ite any injury or of once. Metro Crematory 11-19-12 4 Donation 5 Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee Manus Reverse of Sacilisions Mortuary, 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter me disease. It complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ng physicien end es the buriei-trensit The iew requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 9 cete hes been sig pege 2 shouid b 1 🗌 Yes 2 SHNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours efter deeth.
• Funerel Director: After this certificate I ietely filled in by the funeral director. peg 1 ☐ Yes 2 ☐ No Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဍ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospitel or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 2 Accident Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical To the Hosp within 24 hou To the Funer completely file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse-Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Stephen Olexo Step hin

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

NOV 2 0 2012

Box 68760

Records,

of Vital

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ W Wallace Earmon 1:30 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Nov 20 1 Days Hours 219-32-8211 Director 1**X** M 2 □ F 1937 Maryland 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show treumetic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 USA 96 C Mary Lane Apt 204 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Yes 2 No If Yes, Give δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: **Black** 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed 10th 0 Upholstery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Wallace III Carrie Bias permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke eny injury or other treumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Bay Green Dr. Arnold, Md. 21012 Carlos Wallace(Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 11 - 20 - 12Crownsville, Md. 4 Donation 5 Other (Specify) Winname Revenues of Secilis ons Mortuary, P.A. 21. Signature of Funeral Service Licenses 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatie ease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use es the burlal-transit Exam or Attending Physicien: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate Yes 2 No hin 24 hours after death.

the Funeral Director: After this certifica

mpletely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 🗹 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Many of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the F complet only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

34

State

John

31 Date filed (Month, Day Year)

30. Narge and address of person who completed cause of death (Item 23a) (Type, Print)

3900 Loch Raven Boulevard, Baltimore, Maryland 21218
10 32. Affistrar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5: 15A M Marian E. Wright November 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 30 Fox Brier Lane Nottingham Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 190-18-9721 Director 1 🗆 M 2 🖾 F 4/4/1923 Pennsylvania 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Nottingham Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 30 Fox Brier Lane USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White 3 🕅 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) LPN Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne) ည James Sutliff Anna Loftos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Fox Brier Lane, Nottingham, Maryland 21236 Margaret McMahan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Sepulchre 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any Injury or ot 1 X Burial 2 Cremation 3 Removal from State 11-21-2012 Philadelphia, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatural Fineral Service Licensee 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute myelogenous Leukemia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner myeloproliferative Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). sician and burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician thed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ischemic Cardio Myopathy 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Atherosclerotic Cardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 N 1 ☐ Yes 2 ☐ No al or Attending Physician: 1 s after death. I Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ne Hospital or Attending Phys in 24 hours after death. ne Funeral Director: After this opletely filled in by the funeral dir 28a. Date of injury (Month, Day, Year) Certificate: 27. Manper of Death 28b. Time of 28c. Injury at 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Box 68760

Records,

Division of Vital

State Registrar 29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 2 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signat

Thomas Wilson MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Gertifying Nurse Practitioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

040277

5601 Loch Raven Blud, Baltimore MD 21239

29d. Date signed (Month, Day, Year) November 19,2012

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0506M 20 amue 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 579-48-9021 1 1 X M 2 □ F 01/20/1933 Marvland 79 Usual Residence of Decede item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10h Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Marvland | Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21140 United States 2704 Cedar Drive 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?. should be filed within 72 hours after dand Mental Hygiene.

is marked other than "natural", or it Black, White, etc. à 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Linda V. Soper Thomas E. Wood permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2704 Cedar Drive, Riva, Maryland 21140 Maureen Wood/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakemont Memorial Gardens 11/27/2012 Davidsonville, Maryland 21. Signature of Juneral Service Lice 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ COMPLICATIONS OF ASTHMA AND LARYNGOSPASM disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Non-insulin dependent diabetes mellity anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hyperlipidence Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Gastnoesophereel Redlux Generalized Anxiet 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Kenel Artery 24a. Was an autonsy performed? -Yes 2 □ No 1 ☐ Yes 2 🖾 No Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🗷 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury ours after death. Jeral Director: Aft filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier 1, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number (cu m) D31997 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SE100 ANDREW GORDON ND 2003 Medical PKW. NUD ANNAPOUS,

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year) NOV 2 6 2012

			1 - State Registrar		Cer	tificate of	Death	·	Reg. No.			
	Dhysicis	n/	1. Decedent's Name (First, Middle, La.	st)				2. Date of De	eath		3. Time o	f Death
wild.	Physicia Medio			White, Sr.				Novemb	oer 14,	2012	5:59	$\mathbf{P}^{M}$
	Examir	er	4a. Facility Name (if not institution, give			4b. City, Town, o	or Location of D	eath		y of Death		
r gat			Heartland of Hya  5. Social Security Number 6. S		- t- that to	Hyatts If Under 1 Year					orge's	
	Funeral Director		212 17 2000	ex 7. Age (in )  □XM 2 □ F 9	rs. last birthday)  1 Yrs.	Months Days		Ain. (Month, Da		Count	olace (State d try) <b>ginia</b>	or Foreign
	and show at	5	10a. State 10b. County	10c	. City, Town or Lo	cation				10	0d. Inside Ci	ity Limits
	Aaryla 8a-f s tified	Director	District of Co	lumbia	Washin	gton						s 2 $\square$ No
	the N		10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	try?	
	s 23s	Funeral	4227 Eads Street	, NE		20019			United	State	es	
	death item ner n		11. Marital Status	12. Was Decedent Ever in Armed Forces?		Vas Decedent of F Yes, specify Cub		(Specify Yes or No-	14. Ra	ce - America	an Indian,	
0036	urs after ural", or Il Exami	ted by	1 Never Married 2 Married 3 XVidowed 4 Divorced	1 ☐ Yes 2 ☐ <b>X</b> No If Yes, Give Year or Dates.		☐ Yes 2X No		,	Specify	ick, White, e /:	Black	
21215-0036	in 72 hou e. nan "nat Medica	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give I	lent's Usual Occup kind of work done O NOT use retired,	during most of	working	16b. Kind of E	Business/Ind	lustry	
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nd	filed tal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Surnam	re)		
yla	uld be I Men narke natic	1	Robert J. White				Estell	e Howard				
, Maryland	nd 2 shou ealth and m 27 is n		19a. Informant's Name/Relationship (7) Gerald B. White					Rural Route Number Walton H				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci.	Removal from State		natory or other pla		Date v 24, 201	20c. Location  2 Suit	- City or Tov $1$ and,		
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licens	1 SMOOF				Stewart F d, NE Was		-		
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	plications that caused the one cause on each line.	death. Do not ente		ng, such as card	diac or respiratory ar	rest,		Approximat Interval Bet Onset and I	ween
	Medical		disease or condition resulting in death)	Due to (or as a cons			quace	POCTUT		-		
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	p it	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):	11		5 1				
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8760	cate   phys	Medical		d								
P.O. Box 68	e death certificate be executed the attending physician and hed for use as the burial-transi	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1  Live Birth 2  4  Pregnant at time 9  Unknown	Fetal death 3	Ectopic pregnan Other (specify)	су			ate of deliver	*	Year
Ö.	The law requires that the der ate has been signed by the a page 2 should be detached	y Ph	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco use conf	tribute to the	e cause of d	eath?
	uires t n sign uld be	q pe	Congestive Ho	art Faile	uno			_ 1 🗆	Yes 2 No	3 Proba	ably 4 🗌 I	Unknown
oro	v requ	olete	Hyporta	insim				24a. Was	an 24b.	Were autops	sy findings a	available
şec	he lar te har	E	Damontin						rmed?	death?	npletion of c	ause of
a	ysician: The law is certificate has director, page 2		25. Was case referred to medical			26. P	lace of Death (C		2 No	1 ☐ Yes 2	2 🗆 No	
<u> </u>	nysica lis ce I direc	10 E	examiner? 1  Yes 2  o	Hospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 □ DOA Oth	er: 4 🗷 Nursin	g Home 5 ☐ Resid	dence 6 🗆 Oth	er (Specify)		
of	ng Pl fter th unera		27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, Year	28b. Time of injury	28c. Injur work	y at		now injury occur			
<u>o</u>	tendi leath. or: A the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not b			M 1 🗆	Yes 2 No					
Division of Vital Records,	tal or Attend rs after death al Director: A led in by the f	al Certificate:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe		et, factory, office		28f. Location (S City or Tou	Street and Numb vn, State)	er or Rural F	Route Numb	er;
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check 2 L Medical Exami	sician: To the best of my kr ner: On the basis of examinate Practitioner: To the best	ation and/or investi	gation, in my opini	on, death occurr	ed at the time, date a	and place, and du	e to the caus	se(s) and mai	nner stated
	Vithi Control		29b. Signature and the of certifier			200 Licone	o mumbar		00 I D-1	1.01.4		
			MY MO			4	1867		11/21/	2012	-	
	450		30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type, Pi	int) # 216.	Rocku	ille, MA	2085	Z		
	Stat	_	31. Date filed (Month, Day, Year)	02. Registrar's Sig	gnature			/				

12-08730	
Daniel Wax	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

•		1- For State Registrar	Certificate o		id Mentar		g. No. 201	2 4025
Physicia edical Exami	an/	Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
CUICAI EXAIIII	ner	Daniel W. Wax  4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	or Location of De	Month November	17, 2012 4c. County of Dear	0842 hrs
		Peninsula Regional Medical Center		Salisbury			Wicomico	
Funeral Director		221-68-7386 1XM 2F	e (In yrs. last birthday) 33 Yr	If Under 1 Ye Months Da		Ars. 8. Date of Birt Min. 05/09	h(MM/DD/YYYY) 9. B /1979 C	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	ation		<del>-</del> ,		10d. Inside City Limits
Aaryland 28a-f show I at once.	ō	Maryland Wicomico	Fruitlan	đ				1 X Yes 2 No
15-0036 filed within 72 hours after death with the Maryland Hygene. ed other than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be notified at once.	Director	10e. Street and Number 509 Sheldon Ave.		10f. Zip Code 2182	26	10	og. Citizen of What Coo USA	untry?
leath witl r items 2	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2		as Decedent of F Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
urs after c tural", o	Ş	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade com	1	Yes 2 X N		of work done	Specify: Wh	ite
D36 thin 72 ho re. than "na redical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5	during n	most of working lit	fe. DO NOT use i	retired)	Automoti	
5-00 ed with tygien other	Co	17. Father's Name (First, Middle, Last)	Date		18.Mother's Na	me (First, Middle, N		<u> </u>
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Bruce M. Wax	Lagida		_	nn Sutton		
re, MD 2121 1 and 2 should be fi F Health and Mental If item 27 is marked er traumatic event,	ᅀ	19a. Informant's Name/Relationship (Type, Print)  Bruce M. Wax/Father	1				ber, City or Town, Stat y, MD 2180	
or Health		20a Method of Disposition  1 Burial 2 X Cremation 3 Removal from Sta	20b. Place of Dispo	sition (Name of c		Date	20c. Location - City o	
Baltimore, permit. Pages 1 at Department of Hec Important: If ite injury or other tr		4 Onation 5 Other Specify:	Salisbury	/ Cremat		./26/2012		
Bal Bermi Depar Im inju		2 Single of Francisco Licensee	- CT3F1 :	OUT SHOW	DITT KO	l / Dalis	JULV, PID Z.	Association 1804
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter	the mode of dying	g, such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Atterosclerotic Countries and Due to (or as a conse	Cardiovascular Dis equence of):	sease compi	cated by 101	so injuries		
	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	equence of):					
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60, ate be exchysician	Medical	UNPENDED AMENDED						
Sox 6876 leath certificat e attending ph for use as the	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcon	2 F	etal death 3	Ectopic preg	gnancy	23d. Date of delive Month	ry Day Year
Box 687 e death certific the attending p	Physici	1 Yes 2 No 9 Unknown 9 Unknown	time of death 5 0	ther (Specify)				
P.O.	ē	Part II. Other significant conditions contributing to death	h but not resulting in the	underlying cause	given in Part I.		bacco use contribute to	
Cords, P.O.  law requires that has been signed b	Completed					24a. Was a autop:	sy prior to	utopsy findings available completion of cause of
Vital Recysician: The his certificate director, page		25. Was case referred to medical		26 Dia	on of Dooth (Cho	1 ✔ Yes	2 No 1 🗸 Y	res 2 No
Vital  bysician this cert	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatie	ent 2 🗹 ER/Outpatien		Other Nur		Residence 6 Othe	эr:
After funerz	tion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju (Mouth, Day X Nov 17, 2012	28b. Time of 0815 hrs	Injury 28c. In	iury at Work? Yes 2  No		ow injury occurred ixed object collisi	on
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Suicide Could not be	jury - At home, farm, stre jor Road / Highway		building, etc.	or Town, St		ural Route Number, City Fruitland, MD
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner and manner stated.						
E 3 E 8	¥.	29b. Signature and title of certifier			nse number		29d. Date signed (Me	
		ひ_ひ		0.0	.M.E. 		November 18, 2	2012
ate		Name and address of person who completed cause of d     Donna M. Vincenti, MD		) W. Baltimor	e Street, Bai	timore, MD 21	223	
St Regist	ate rar	31. Date filed (Month, Day Year) 2012 32 Registrar	r's Signature	Kal				

DHMH 17 Rev 1/2001 OCME 2006

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Linda Lee Willey November 19, 2012 12:05 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🕱 F Months Days Hours 0912211949 Director 63 218-58-2442 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Direct 1 X Yes 2 No Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 112 Ridgefield Lane 21826 USA Hygiene. other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
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Holloway Funeral Home P.A. 21. Signature of Funeral Service Ligensee vid 4 501 Snow Hill Rd., Salisbury, Maryland 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Bilal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Day Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Vunknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident injury 5 Pending work? 2 No Investigation completed filled in by the 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Records, Division of Vital 24 hours after death. Funeral Director: A within 2.

Box 68760

P.O.

21215-0036

State Registrar only one

30. Name and addre

31. Date filed (Month, Day,

3 29b. Signature and title of certifie

s of p

NOV

Shack

951

MD

on who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

A.M. Hermon Rd

29d. Date signed (Month. Day, Year)

				AMEND #25, PER	ase Type or F MD G934 12 State of	<b>Print in</b> <b>/12/12</b> Marylar	Black 7 TRT id / Dei	Indelible partment o	<b>Ink. E</b> of Healt	<b>nsure A</b> th and M	II Copie	es Ar vaien	e Legi	ible.	
				for State Registrar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ertificate d				Reg. N	20	12	40260
	I	Physici Medi		1. Decedent's Name (First, Middle MARY AD	,	WHEEL	ΕR				2. Date of Do	D	25 -	Year 2012	3. Time of Death 2:20 a M
		Exami	ner	4a. Facility Name (if not institution		ENTE	R.	4b. City, Tow		tion of Death		4	c. County	of Death	#\$
4		Funeral		5. Social Security Number	6. Sex 7	Age (In yrs.			ear If Ur ays Hou	nder 24 Hrs. Irs Min.	8. Date of Bi (Month, Da				lace (State or Foreign
7		Director ≥		220-42-0909 Usual Residence of Decedent	1 □ M 2 🙀 F	71	Yrs.				MAY 2	0,1	941	MARY	LAND
1	`	ryland -f sho ied at	ctor	10a. State 10b. County  MD CHAR			ty, Town or l							1	0d. Inside City Limits
X		he Mai or 28a o notifi	Funeral Director	MD CHAR  10e. Street and Number	TES	ь	A PLA	10f. Zip Co	ide			100.0	Citizen of W	hat Coun	trv2
08		with t s 23a ust be	eral	l HICKORY LA	NE				20646				U. S		,
2		after death with the Maryland II", or items 23a or 28a-f sho xaminer must be notified at		11. Marital Status	12. Was Decede Armed Force	es?	S. 13	Was Decedent	of Hispanic	Origin? (Spe	cify Yes or No- Rican, etc.)		14. Race		an Indian,
	0036	s after ral", o Exam	ed by	1 □ Never Married 2 □ Mar 3 🛣 Widowed 4 □ Divorced	If Von Give			1 ☐ Yes 🗶 🗓	No <i>Sp</i> e	cify:			Specify:		
>		2 hour "natu edical	Completed		nt's Education est grade completed)		16a. Dec	edent's Usual Oc e kind of work do	ccupation one during r	most of workir	ng	16b.	Kind of Bu	siness/Inc	lustry
7	212	vithin 7 liene. rr than the M	Con	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT use reti EMAKER	ired)			AT	ном	E	
2	nd	e filed within 72 hours after death with the Maryland tal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, I					18. M	other's Name	(First, Middle				
	Maryland 21215	should be filed within 72 hours after death v and Mental Hygiene. 'Is marked other than "natural", or items 'aumatic event, the Medical Examiner mu	F	ROBERT FRAN  19a. Informant's Name/Relations		1			_		GERTR				
DI	1	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		YVONNE SWANN  20a. Method of Disposition			5210	iling Address (Str	JRY R	D.,MA	RBURY	, M	D 20	658	
1	Baltimore	age 1 age 1 ant of h		1 🔀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		ate	cemetery, cr	position (Name o ematory or other HEART	place)	1	ate		Location -	-	
2	alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L		JSA		22. Name and A							
5	. 🕮			for your	1 900	MOO					_		PLAT	A,MI	20646
		Ph <sub>y</sub> sician		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	only one call in each		th. Do not er	nter the mode of	dying, such	as cardiac of	respiratory	rrest,	26	٠	Approximate Interval Between Onset and Death
		Medical Examiner		resulting in death)	ue fi (or	as a consequ	ue of):	Ask	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	~ i	1				
	1100	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of		-0 24	1 , 221	$\sim$				-
		e executed alan and urial-transit		that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):	10	000	<del>2</del> 00					
	200	cate be physic s the b	edica		d										
ı	. Box 68760	Attending Physician: The law requires that the death certificate be streets. After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the b.	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 rtonths? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outco 1  Live Bir 4  Pregna 9  Unknov	th 2 🗀 Feta nt at time of c	al death 3	☐ Ectopic preg☐ Other (specif					23d. Date Mon		ry Day Year
5	P.O.	that thured by	by PF	Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the	underlyin <b>g</b> caus	e given in P	Part I.	23e. Did t	tobacco	use contrib	oute to the	e cause of death?
B	rds,	equires een sig nould b	eted								1 🗆	Yes 2	X No :	3 🗌 Prob	abiy 4 🗆 Unknown
I	Records,	e law n e has b ge 2 sl	mple								24a. Was auto		pr	ere autop ior to con eath?	sy findings available apletion of cause of
	a R	ian: Th rtificate stor, pa	Be Co	25. Was case referred to medical				26	6. Place of [	Death (Check	1 L Yes	2 N	lo 1	Yes	2 □ No
	f Vit	hysici this ce at direc	은	examiner? 1 Yes 2 No				ent 3 L DOA		Nursing Hor	ne 5 🗆 Resi	dence	6 🗌 Other	(Specify)	
	Division of Vital	eath. or: After the funer	Certificate:	27. Manner of Death  1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation	injury Day, Year)	28b. Time of injury	200. 1	njury at work? 1 ☐ Yes 2		8d. Describe I	how inju	ry occurred	d	
	Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	al Cert	4 ☐ Homicide determ	ined 28e. Place of building,	etc. (Specify	)	treet, factory, off			City or Tov	vn, State	e)		Route Number,
		he Hospi in 24 hou he Funer ipletely fil	Medical	(Check Medical E	Physician: To the best xaminer: On the basis of Noxse Practitioner: To	of examination	n and/or i <u>nve</u>	stigation, in my o	pinion, deat	th occurred at t	he time, date a	and plac	e, and due '	to the cau	se(s) and manner stated.
4		Noth Com		29b. Signature and title of certifier	) A	M		29c. Lic	ense numbe	062	9.	29d. Da	ate signed	Month, D	y, Year)
				30. Name and address of person	who completed caused	of death (Item	23a) (Type,	Print)	11	)Ac	DUR	(- V	no	2	0603
		Sta Registra		31. Date flied (Month, Day, Year)	7	strar's Signat	ture	backer	1						

			AMND #25, 26 PER	e Type or Print in	n Black I	ndelible Ink	. Ensure	All Copie	s Are L	.egible.	•
			T _ State	State of Maryi		artment of H <i>rtificate of D</i>		Mental Hy	/	012	40261
			Registrar  1. Decedent's Name (First, Middle, La	ast)	O G	tillcate of D	reau i	2. Date of De	Reg. No.	, top I have	3. Time of Death
	Physicia Medi		Mary Eliza	beth You	ING			Wavem	ber ber	4, Year	2 726 AM
1	Examir	ner	4a. Facility Name (if not institution, give Baltiyore Washive	MAIN	NTER	4b. City, Town, or	Location of Deat		4c. Cc	ounty of Deat	h
Ē	Funeral Director				7 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir	v. Year)	Cot	thplace (State or Foreign untry)
	aryland ia-f show ified at	Funeral Director	10a. State 10b. County	_	City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🗶 No
	the Malor 28	ä	MD Anne A:  10e. Street and Number	runder   G	len Bu	10f. Zip Code			10g. Citizer	n of What Co	untry?
	th with ms 23 must	ner	202 Crain Court			21061				ed Sta	ates
920	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	٤	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 X No If Yes, Give Year or Dates.		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🏿 No		pecify Yes or No- o Rican, etc.)		. Race - Amer Black, White ecify:	
2-0	natur dical	plete	15. Decedent's (Specify only highest g	Education	16a. Dece	dent's Usual Occupa kind of work done du	ition	rkina	16b. Kind	of Business/I	
21215-0036	within 72 giene. ier than	Completed	Elementary/Secondary (0-12)  12	College (1-4 or 5+)	Ìife. D	o NOT use retired) naker	aring most of wor	rking	Own	Home	
and	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle,	Maiden Sun	name)	
Maryland	should be file and Mental H 7 is marked o raumatic eve		Robert Johnson 19a. Informant's Name/Relationship (		19h Mailir	an Address (Street a		Jackson		un Stato 7ir	Code) 21061
	and 2 sh Health ar tem 27 is other trau		Tracie Young/I		1						Burnie, MD
Baltimore,	o o == ==		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	20b	o. Place of Dispo cemetery, crer	sition (Name of matory or other place	e)	Date	20c. Locat	tion - City or	Town, State
Iţ.	permit. Page Department o Important: If any injury or once,		4 Donation 5 Other (Spec	ify) Ce		ill Ceme		12/12	Suit	land.	MD
Ba	permit. Departr Imports any injt		21. Signatur of Funeral Service Liger	1 / /		2. Name and Address			Ja P	al Sv lata,	c., P.A. MD 20646
Г		Г	23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the de						<u>raca,</u>	Approximate Interval Between
a di	hydician/		Immediate Cause (Final disease or condition	a Corona	ru A	rteru	disea	use -	MI	20	Onset and Death
)	Medical Examiner		resulting in death)	Due to (or as a cons	eque co of):	2					
		iner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):						
	executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events	C							
		I— I	resulting in death) Last	Due to (or as a conse	equence ot);						
68760	ficate g phys as the	Nedi		d							
. Box 68	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	23c. If yes, outcome of pred 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d	d. Date of deli Month	ivery Day Year
P.0	that the		Part II. Other significant conditions	4	resulting in the u		en in Part I.	23e. Did to			the cause of death?
ds,	v requires that been signed to should be det	ted	Uncontrolle		etes	Me II, I	DIS	1 🗆	Yes 2X	Vo 3□Pr	obably 4 🗆 Unknown
Vital Records,	The law re cate has be page 2 sh	Completed by	Uncontrol	led Hypi	exter	15100		24a. Was autop perfo 1  Yes		24b. Were auto prior to c death? 1 ☐ Yes	opsy findings available completion of cause of
ital	s <b>ician:</b> The certificate irector, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ XNo	Hospital:		Othor	ce of Death (Chec				
of V	ding Physician: h. After this certific funeral director,	e: To	27. Manner of Death	1 X Inpatient 2 28a. Date of injury	28b. Time of	28c. Injury	4	lome 5 Resident			fy)
lon	Attending ar death. ector: After by the fune	ficat	Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not I		injury	M 1 □ Y	′es 2 □ No				
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	al Certificate:	3  ☐ Suicide 6  ☐ Could not I 4  ☐ Homicide determined			eet, factory, office		28f. Location (S City or Tow		ımber or Rura	al Route Number,
	the Hosp thin 24 hou the Funer mpletely fil	Medical	(Check 2 \( \subseteq Medical Exam	vsician: To the best of my kno niner: On the basis of examinates Se Practitioner: To the best of	tion and/or invest	igation, in my opinion	, death occurred a	at the time, date a	and place, and	d due to the ca	ause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier			29c. License				igned (Month,	
			20 Name and district	Sol	MD	DO	0679	8/	11/	105/	2012
			30. Name and address of person who  140 6 B C V C 31. Date filed (Month, Day, Year)	un Hwy S	Ste	<b>¬</b>	Glen	Burn	ie h	1D 0	2106/
	Stat Registra		on bate filed (infortin, bay, rear)	32. Registrar's Sign	FC 1 2 2	012	4	hade	1		

### Please Type or Print in Black Indelible lak. Ensure All Copies Are Legible.

Bonnie Grace An	tho	ny-Garde S	tate of Maryla	nd / Departr	ment of	Health and	Mental Hy	giene		
		I- For State Registrar		Certif	icate of	Death			No. 2012	4026
Physicia Medical Examin		Decedent's Name (First, Mid     BONN   E GRACE AN						2. Date of Death Month December	Day Year 10 2012	3. Time of Death 2334 hrs
	<b>.</b>	4a. Facility Name (if not institut		mber)	4	b. City, Town, or L	ocation of Death	200020	4c. County of Death	
		6656 Roberts Court	Apt C95			Glen Burnie			Anne Arundel	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs, last I	birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.		(MM/DD/YYYY) 9. Birth Foreign	1
Director		218.64.0882	1 M XX F	50	Yrs.			DECEMBER	16, 1961 Cou	ntry) <b>MD</b>
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	/	10c. City, To	wn or Location	on				10d. Inside City Limits
<b>*</b> .	اڃ	MD ANNI	E ARUNDEL	GLEN	BURNIE	Ī				1 Yes 2 XX No
faryla 28a-f	Director	10e. Street and Number				10f. Zip Code		109	g. Citizen of What Coun	try?
3a or		514 CRAIN HWY	N STE K	_		21061			USA	
death with the Maryland or items 23a or 28a-f show must be notified at once.	Jera	11. Marital Status  1 Never Married 2 XX				Decedent of Hisp es, specify Cuban,			14. Race - Americ White, etc.	can Indian, Black,
er dea	Funer		1 Yes	2 <b>XX</b> No	1	Yes 2 XX No	specify:		Specify: WHI	TF
0036 within 72 hours after death with the Maryland grene. ber than "natural", or items 23a or 28a-f she Medir I Exeminer must be notified at once	ā S	15. Decedent's Education (Sp	or Dates:		Sa. Decedent	st of working life.	on (Give kind of w		16b. Kind of Business/Ir	
6 72 hc	lete	Elementary/Secondary (0-12	College (1	-4 or 5+)	auring mo	ost of working life.	DO NOT use retir	ea)		
within within Media	Completed	12 17. Father's Name (First, Midd	la Last)		НС	MEMAKER 1	8.Mother's Name	(First Middle M	OWN HOM	<u> </u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medi-	Be C	JAMES THOMAS AN				l'	JOAN MARI		aldon ballano,	
212 212 212 Menti mark		19a. Informant's Name/Relation			19b. Mailing	Address (Street			ber, City or Town, State,	Zip Code)
MD d 2 sho lth and lth and numati		CHRISTINA H. DU	NCAN			Y DR. MANC				
_ C 77 27 27		20a. Method of Disposition  1 Burial 2 Cremati	on 3 Removal fr	om State crei	matory or oth			Date	20c. Location - City or	
imo Page ment c		4 Donation 5 Other	Specify:	BAYVI		IATORY INC		.2012	BALTIMORE,	MD
Baltimore, permit. Pages I a Department of He (mportant: If ite		21. Signature of Funeral S		1148		REPUNERALS CRAIN HWY			21061	
Physician	$\dashv$	23a. Part I. Enter the disease,	or complications that of							Approximate Interval
/Medicar		failure. List only one cause immediate Cause (Final disea	0	stinal Hemorrh	age					Between Onset and Death
xaminer		or condition resulting in death	Due to (or as	consequence of):						
Star and	_	Sequentially list conditions, if any, leading to immediate	b. Chronic Al	coholism a consequence of):						
	nine	cause. Enter underlying Cause (Disease or injury that initiated	C.							
ist of H	Examine	events resulting in death) Las	t Due to (or as	consequence of):						
e executed ian and ial - transit		UNPENDED	dAMENDED				<u> </u>			
	Physician/Medical	IF FEMALE:		outcome of pregnar	ncy				23d. Date of delivery	
687 ertifica ding p	ian/	23b. Was decedent pregnant in past 12 months?	I Live	oirth nant at time of death		tal death 3	Ectopic pregna	ancy	Month D	Day Year
Box 68760 e death certificate b the attending physical for use as the bu	ysic	1 Yes 2 ✔ No 9 U	Jnknown 9 Unkr		1 5 Ot	her (Specify)				
O. But the d		Part II. Other significant con-	ditions contributing t	o death but not resu	ulting in the u	ınderlying cause g	iven in Part I.		bacco use contribute to	
F. P.O. ires that the signed by the detached	d by	Hypertension; Diab	etes Mellitus					15	2 No 3 Prob	
ords, w requires been should	olete	III						24a. Was a autop:	sy prior to d	topsy findings available completion of cause of
Recol The law cate has	Completed							perfor		es 2 No
Division of Vital Records, P.O. to or attending Physician: The law requires that the rafter ceath.  To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Bec	25. Was case referred to med examiner?	ical Hospital:				of Death (Check			
of Vil ing Physic	70	1 Yes 2 No 27. Manner of Death			R/Outpatient		Other Nursir		Residence 6  Other	r: Scene
In of viding Phy. h. : After the funeral	ion:	1 A Notural	(Mont	of Injury h, Day,Year)	ob. Time of		res 2 No	201. 200		
isio	Certification:	2 Accident In	vestigation	ce of Injury - At hom	ne, farm, stre	et, factory, office b	uilding, etc.	28f. Location (S	Street and Number or Ru	ıral Route Number, City
Div	erti	Outcide	etermined (Specify	)				or Town, S	tate)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after ceath.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	calC	29a. Certifier 1 Certifying	Physician: To the be	st of my knowledge	, death occu	rred at the time, da	ate and place, and	due to the caus	e(s) and manner as stat and place, and due to th	ed.
To th within To th	Medical	one) 2 Medical E  29b. Signature and title of cer	and manner	stated.	/or investiga	29c. Licens		at the time, date	29d. Date signed (Mo	
	2	29b. Signal die and title of cer	1)	\		O.C.I			December 11, 2	_
3		30 Name and address of pers	on who completed on	ise of death (Item 2	3a)					
		Laron Locke MD.	Assistant Medic			altimore Stree	t, Baltimore,	MD 21223		
	tate			tegistrar's Signature					· · · · · · · · · · · · · · · · · · ·	<del></del>
Regis	trar	DFC 1 3	2012 Same	w B.	parke					
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ VIRGINIA LEE WHITE NORRIS ANDREAE DECEMBER 08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 220-44-5803 Director 1 □ M 2 🛛 F 92 Jan 28, 1920 Department of Heelth and Mentel Hyglene importent; or items 23e or 28a-f show importent; if item 27 is merked other then "neturel", or items 23e or 28a-f show eny Injury or other treumetic event, the Medical Examinar must be nutflied at engine. Since. 10b. County 10c. City, Town or Location ild be filed within 72 hours efter death with the Maryland Mentel Hyglene. Director Maryland Baltimore County Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funerai 21204 USA 1055 West Joppa Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 21215-0036 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Elementary School Teacher Balto. City Schools Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) George Matthew White Gertrude Eliza Heller . Page 1 end 2 should b tment of Heelth end Mer tent: if item 27 is merk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Lee Norris McCabe (Daughter) 307 Woodlawn Road, Baltimore, Maryland 21210 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Pikesville, Maryland Oruid Ridge Cemetery 12/17/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature (f) uneya Sérvi Licens u MATTCHERT WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) After this certificate has been signed by the attending physician and structor, page 2 should be deteched for use es the burlal-trensit Hospitel or Attending Physicien: The lew requires that the deeth certificete be executed ause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month ☐ Yes 2 🖸 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funerei Director: After this certifice completely filled in by the funeral director, i 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie POV n who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12:19PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between

1 ☐ Yes 2 ☐ No

3 days

1 Tes 2 No

Maryland

201

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month Devr Year)

CharlesSt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:50 AM ESTHER WINOMA ALLEN December 12. 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS Timonium Baltimore County Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Jan 21, 1919 Mary Land **Director** 216-12-3321 1 🗆 M 2 🗶 F 93 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Baltimore County Timonium 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 X Never Married 2 Married Black, White, etc. ≥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be flied within 72 I Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other traumatic event" 4. 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Collections Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Columbus Allen Ada Lilian Harlan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 E. Joppa Road, Suite 200, Towson, MD 21286 Craig D. Spencer (Friend) 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Metro Cremaoty, Inc. 12/13/2012 Baltimore, Maryland 21. Signature of Funeral S. rvol Liber ..... Mitter Lice in Funeral HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D . Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE STHEE disease or condition resulting in death) MA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 2012 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Year signed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BRIERY director, page 2 should be Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been PNEUMONIA-24a. Was an Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 2 No မ 1 🗌 Yes Other: To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directorial. 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The Gertifying Physician: To the best of the showledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 only one) 29b. Signature and title of certifier Bees CRN R043580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year Wayne Anthony Altomonte Month 11 8:15P Dec Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 217-11-7173 Director 42 3-10-1970 MD or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Maryland 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1137 Old Westminster Pike 21157 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Inspection Fire Safety Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viki Anders Wayne Altomonte, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 Cyndi Altomonte-wife 1137 Old Westminster Pike, Westminster, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of Informatic If Ite any Injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 12/13/12 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Central MD Crem 21. Signatur funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral & Cremation St., Westminster, MD 21157 Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) NEEK Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sicien and burlal-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien I for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live retailed Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Month rate has been signed by the a page 2 should be detached to a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 2.2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) DCVE HOU nours after death.

neral Director: After this

filled in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OUP ISHANK State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40266 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hildegard Allen Month 1Pey 2012 4:07p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 200 Angus Drive Aberdeen Harford Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country)
 Germany 03/04/1930 **Director** 087-42-7025 1 M 2 XF 82 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Harford Aberdeen 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Angus Drive 21001 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. \$ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene, marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 house wife in home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ρ George Richardon Dorothea Glockler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard T. Allen (husband) 200 Angus Drive, Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Everial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Arlington National Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ MXOCAYd disease or condition resulting in death) Has Medical Due to (or s a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): attending physician and for use as the burlal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? ρ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after deatn.
 Funeral Director. After this certificate has be betely filled in by the funeral director, page 2 s autopsy perform 1 ☐ Yes 2 ☐ N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{\text{Nursing Home}} \) 5 \( \text{\text{Residence}} \) 6 \( \text{\text{Other}} \) Other (Specify) 1 ☐ Yes 2 🜠 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the I only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HILAK MD Ave ZN Num State Registrar

DHMH 17 Rev 06-2011

To the Hospital or Attending Physiciao: The law requires that the death certificate be executed within 24 hours after death.

To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

ō	Maryland Anne Arundel	Mi11	ersville				1 Yes 2 X No
, <u>5</u>	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?
Funeral Director	742 Cecil Avenue North		21108			USA	
ler.	11. Marital Status 1 Never Married 2 Married Armed Forces?		Was Decedent of His If Yes, specify Cuban			- 14. Race - Amer White, etc.	ican Indian, Black,
	3 Widowed 4 Divorced If Yes, Give Year or Dates:	No 1	Yes 2 X No	specify:		Specify: Wh:	ite
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Completed by	Elementary/Secondary (0-12) College (1-4 or 5-	+)	g most of working life.	DO NOT use ret	irea)		
E	12 17. Father's Name (First, Middle, Last)	L	aborer	10.14-1-1-1-1	· /First Addulla A	Constru	ction
BeC			1			faiden Surname)	
O B	Wilmer Richard Borgmann Jr.  19a. Informant's Name/Relationship (Type, Print)	19b. Mai	iling Address (Stree		Ann Fel	. CO ber, City or Town, State	. Zip Code)
-	Patricia A. Sanza, Sister	1.0	Mudd Lane		ock, PA	•	, _, _,
	20a. Method of Disposition	20b. Place of Disp	position (Name of centroller place)	netery,	Date	20c. Location - City or	Town, State
	1 Burial 2 Cremation 3 Removal from Stat 4 Donation 5 Other Specify:	° l	ematory Ir	12	/13/12	Baltimore	Maryland
	21. Signature of Funeral Service Censee Thomas G	recor 2	2. Name and Address	of Facility	715/12	Dartimore	, talyland
	Thomas Xugar	12	2. Name and Address remation S 99 Frederi	ck Road	Of Maryl Baltin	and, Inc. Maryla	and 21228
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	Immediate Ceuse (Final disease a Multiple Injuries						Death
	or condition resulting in death)  Due to (or as a consection)	juence of):					
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Exa	events resulting in death) Last Due to (or as a consec	uence of):					
Physician/Medical Examiner	d. UNPENDED AMENDED				···		
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ian/	23b. Was decedent pregnant in the past 12 months?	~	Fetal death 3	Ectopic pregna	ancy		Day Year
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0	25. Was case referred to medical		26.Place	of Death (Check			2 110
0 B	examiner?  1 Yes 2 No Hospital: 1 Inpatien:	t 2 ER/Outpatie	ient 3 DOA	Other Nursir	ng Home 5	Residence 6 🗸 Other	: Scene
<u>-</u>	27. Manner of Death 28a. Date of Injury	er)		y at Work?		low injury occurred	motoryphiala
atio	1 Natural 5 Pending Dec 11, 2012  Accident Investigation	0317 hrs	1□ Y	es 2 🗸 No	accident	estrian involved in	motor venicle
ij	3 Suicide 6 Could not be 28e. Place of Inju	ry - At home, farm, st	treet, factory, office be	uilding, etc.	28f. Location (S	treet and Number or Ru	ral Route Number, City
Š		state/Express			SB I 97 at Rou	tate) ite 32, Glen Burnie, N	/ID
Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner.						
Med	and manner stated.  29b. Signature and title of certifier		29c. License			29d. Date signed (Mor	
-	10 1 1/1	Λ Λ	O.C.N	0.01	ME	December 11, 20	
	30. Name and address of person who completed cause of dea	ath (Item 23a)					
	Theodore M. King, Jr., MD. Assistant Me	dical Examiner	900 W. Baltim	ore Street, B	altimore, MD	21223	
tate	31. Date filed (Month) Paryelin 3 2012 32. Engistrar's	Signature	arks!				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:10AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ANNE ARUNDEL MEDICAL CENTER **ANNAPOLIS** ANNE ARUNDEL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Months Hours Director 1 M 2 XXF 050.44.8123 61 Yrs JAN 19, 1951 Usual Residence of Decede pe 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other then "neturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No MD ANNE ARUNDEL **GLEN BURNIE** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 14 GREENWOOD AVE. 21061 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Ď 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 **SUPERVISOR** MD MVA Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental F မ unk **JEAN COLTER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STACY J. WILLIAMS DAUGHTER 1442 BARRETT RD. BALTIMORE, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Importent: If II eny Injury or o 1 Burial 2 XX cremation 3 Removal from State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY INC 12.11.2012 BALTIMORE, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY SW GLEN BURNIE, MD 21061 K. GREGORY FINK M01148 Enter the disease, or com ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List of Immediate Cause (Final peritoneal cancer Physician/ Ovavian disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 as attending p IF FEMALE: use If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has build be build be build be build be build autopsy perform 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No |2 1 Inpatient 2 ER/Outpatient 3 DOA this Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at I Director: After to ad in by the funera 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in 1 To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu and (itle of certifier 29d. Date signed (Month, Day, Year) 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis, Und. 21401 2003 Medical Parkway Studivt Selonick, E. MO 31. Date filed (Month, Day, Year) State 3 2012 DEC Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2012 ALBERT C. BOSS JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ANNE ARUNDEL **GLEN BURNIE** GLEN BURNIE HEALTH AND REHAB If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 20, 1923 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** XX M 2 F Months Days Hours Min. MD 89 Director 214.18.2624 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 3% and injury or other traumatic event. The marked has any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes XX No Director **GLEN BURNIE** MD ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 803 CEDAR BRANCH RD. 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1√1Yes 2 ∏ No IYYes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 □Yes XX No Specify Specify: þ 3 ¥¥Vidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT SUPERVISOR **GENERAL MOTORS** 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ဂ္ ALBERT C. BOSS, SR. **EVELYN MEYER** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 803 CEDAR BRANCH RD. GLEN BURNIE , MD 21061 RAYMOND BOSS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) MDVETCEM CROWNSVILLE 12.13.2012 21. Signature of Furneral Service Ucensee

K. GRECORY FUNK 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** sotwe on /Medical Due to ( as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check onl one) Hospital: Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu 8 s of person who completed cause of death (Item 23a) (Type, Print) AVATION BLUD, SUITEB, GLEN BURNIE, IND 21061 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 8 Robert 12 2037pm Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death of Maryland Medical Cer Baltimore MD A/N7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Unde If Under 24 Hrs. **Funeral** 212-20-5248 1 X M 2 □ F Director 85 03/14/1927 Carolina S. 28a-f show 10b County 10c. City, Town or Location
Baltimore 10a. State 10d. Inside City Limits with the Maryland must be notified at Director N/AMD 1 🔀 Yes 2 □ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a5 S. Arlington Ave. 21223 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc 0 þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specify: Black 1 ☐ Yes 2 No Specify. "natural" Completed 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) the White & Turner Home Improvement Ith and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Bey Ida Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Ravanna Young Bey (Brother 2411 St. Stevens Ct. 3D Balto., MD 21216 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) ò Department Important: If any injury or Arbutus 12/18/12 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave. Baltimore, MD Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Provician/ Due to (or as a construence of): disease or condition Medical resulting in death) Examiner Accident cerebrovas culat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transif Cause (Disease or injury that initiated events Hyperlip. and Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe After this certificate 2 🗆 No 1 Yes funeral director, 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5  $\square$  Pending Natural 24 hours after death. 1 - Yes 2. Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 1720303811

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person w

31. Date filed (Month, Day, Year)

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Baltomore MD 21201

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year Month C Mildred Rae Bruchey 0:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Duni Funeral If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **Director** 217-09-4451 1 □ M 2XX 92 10/12/1920 MD Usual Residence of Decedent or 28a-f show ld be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2XX No MD Baltimore Baltimore, Maryland 21215-0038) White Marsh 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5215 Bush Street 21162 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Completed 3 Widowed 4XX Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 11 Salesperson Department Store permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John E. Thater Melva Early 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Arlene Austin / daughter 501 Kent Circle, Glen Burnie, Maryland 21060 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wallev Mem. 12/15/2012 Timonium, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart range. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsi disease or condition Medical resulting in death) Examiner GASOLOJUITSONA Sequentially list conditions, Examine Due to (or de a concequence of) if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events PCZ FOILITTO CITSING L Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

Yes 2 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 Tes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Cettifying Nurse Practitionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V 13 ALD MOOLE 1ASILITEID~ 1-14.77 MUNICAZ

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Ruth Marie Lamont Bowes To. 2012 9:40 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montaomeru 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 150-16-4321 Director 1 □ M 2 🕶 F 87 09/27/1925 New Jersey Usual Residence of Decedent r then "netural", or items 23a or 28a-f show the Wedled Evaniner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maruland Montgomery Potomac 1 🗆 Yes 2 🖔 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9440 Newbridge Drive. Apt. 112 20854 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian þ Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed witt Depertment of Health and Mental Hygier Important: If item 27 is marked other then Injury or other traumatic event, 11 page. Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Lamont Ethel F. Boule 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancie B. Kenney - Daughter 724 Wilson Avenue. Rockville. Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 12/17/2012 4 Donation 5 Other (Specify) Brentwood, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Cardiac Arrest Medical Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of To the Hospital or Attending Physician: The lew requires that the death certificate be executed attending physicien and for use as the burial-transit Atrial Fibrillation that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Pulmonary Embolism Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has erel Director: After this certificete I filled in by the funeral director, pag performed? Yes 2 X No 1 ☐ Yes 2 ☐ No B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🕱 No Hospital Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funerel D Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0047330 December 12, 2012 WEIN GS

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Registrar

31. Date filed (Month, Day, Year) ... 32. Existrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Thomas V. Joseph.

50 West Edmonston Drive, #207, Rockville, Maryland 20852

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ELVIN ROSLE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death MUTIMORE 25 MARYIAND UNIVERSITY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 216-34-1707 Months (Month, Day, Year) Director 12 M 2 D F 6-6-1936 MD in then "naturel", or Items 23e or 28a-f show the Medical Expringer must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Carroll Westminster 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 South Center St. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Yes 2 No Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 Divorced 4 Divorced Specifywhite Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Dry Wall Finisher Construction Be 17. Father's Name (First, Middle, Last) should be filed thend Mental H Is marked of 18. Mother's Name (First, Middle, Maiden Surname) William Bosley Mary Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health er Importent: If item 27 is eny injury or other treu Jody R. Bosley-wife S. Center St., Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Lake View Memorial 12-15-12 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral & Cremation Main St., Westminster, MD 21157 254 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MULTI SYSTEM FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CEPTEBRAL HEMMORHAGE FRONTAL Sequentially list nonditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ng physician and es the burlal-trensit or Attending Physician: The lew requires that the death certificete be executed resulting in death) Last Due to (or as a consequence of): the ettending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Yes 2 ☐ No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown STRO 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) T ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting Physician. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 DATASHA 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40274 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mildred Baird Month December Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Grace r51114 7. Age (In ywa last birthday) 9. Birthplace (State or Foreign Country) NJ If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛛 F 88 158-14-2831 0772371924 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Forest Hill Harford MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 253 Trudy Court USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify Specify. Completed 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner operator Beautician Beautician Be 18. Mother's Name (First, Middle, Maiden Surname)
Estelle Jenkins 17. Father's Name (First, Middle, Last) John Baird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 253 Trudy Court Forest Hill MD 21050 Michele Renee Davis Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 12/10/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 21076 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. De Immediate Cause (Final 20nset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Lunins Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year been signed by the should be detached Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Tcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/41/2. D32609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Missam ry 406 Kerolution St Harrede Grace 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

OR

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ nistee Year) 1:15 AM Medical Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Crevitsis Knollwood Manor Millersville Anne Avunde If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M 2 F **Director** 219-34-2017 73 Usual Residence of Decedent July 31, 1939 Maryland 28a-f show 10a. State with the Maryland notified at 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No MD Anne Arundel Odenton 10e. Street and Number ō 10f. Zip Code th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be I 10g. Citizen of What Country? 1254 Hollands Avenue 21113 USA should be filed within 72 hours after death and Mental Hygiene.

is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: Black 3 Widowed 4x Divorced Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Private Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Acey Chisley Mary Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline D. Oliver/Daughter 9238 Edmonston Road, Greenbelt, MD 20770 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Riverdale Crematory 12/13/2012 Riverdale, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 90 disease or condition Medical resulting in death) **Examiner** month Sequentially list conditions, It day, leading to immediate cause. Enter Underlying Examiner rdeal Infarction 1 month Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 🕅 No Ectopic pregnancy for Pregnant at time of death Month 5 Other (specify) Day signed by the at Id be detached f Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 1 Yes 2 this certificate 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at 28d. Describe how injury occurred 1. Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2 only one 3 ... Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d, Date signed (Month, Dav. Year 7/12

Registrar

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lark MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month James A. Colter III 6:45 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Hospice Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) Months Director 216-98-1887 1 X M 2 D F 33 Oct. 16, 1979 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23e or 28a-f s 1 X Yes 2 No Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2409 Oak Glen Way 20747 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
Sent: If Item 27 is marked other than "neturel", or Items ury or other treumetic event, the Medical Experient man 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 9 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) None 12th Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Colter, Jr. Sherrie Morman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Colter, Jr./Father 2409 Oak Glen Way, Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State permit. Page Department o Importent: If Donation 5 Other (Specify) 12/15/2012 Suitland, Maryland Cedar Hill Cemetery neral Ser 21. Signatu 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease of Injury Examine Due to (or as a consequence of): To the Hospitel or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Chronic Respiratory Failure Ventilator Dependent that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Urinary Tract Infection Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Severe Kyphoscoliosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Cerebral Palsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🗆 Nursing Home 5 🗆 Residence ex Other (Specify) Casey House 1 ☐ Yes 2 ☐KNo ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 9, 2012 D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) State 3 2012 Registrar

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4	To the within 2 To the Completed	Σ	only one) 3 Certifying Nurse 29b. Signature and title of certifier	racutioner: 10 the b	est of thy Knov		9c. Licens		and place, and ude t		ate signed (/			
			D.M M.D				000	5910	7	12	-12	- 20	012	
	-		30. Name and address of person who con	pleted cause of deat	h (Item 23a) (		-	1 # 0						
	D		KALUUMA 21	0 BUSINE	55 CE	MER !	DRIV	E, RE	ASTERST	w~	Mo	2	1136	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis far's	Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fth 9934 12-18-12 vt
State of Maryland Department of Health and Mental Hygiene 2012 For State Registrar 40278 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 12 Month 12 Elizabeth NMN Cashwell 5:45a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2702 Cator Drive Ft. Washington, USA MD Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Director 1 □ M 2 🕱 F Vrs 83 Charol, 2/9/1928 VA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director or 28a-f 1 X Yes 2 ☐ No Ft. Washington Prince Georges 10f. Zip Code 10g. Citizen of What Country? 23a 2702 Cator Drive 20744 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian "natural", or iter edical Examiner Black, White, etc. 1 Never Married 2 Married 72 hours after Yes 2 No 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 - Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than matic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Federal Govt. Documents Clerk Be 3altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Health and Ment tem 27 is marked other traumatic e Nathaniel Williams Leola Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kirklon Cashwell-son Ft. Washington, MD 20744 2702 Cator Dr., other Important: If iten any injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Landover, MD 12/14/12 National Harmony 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Freeman Funerald., Temple Hills 4594 Beech Rd., MD 20748 23a. Pirt 1 Enter the disease, prcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock or heart failure. List only one cause on each line.

Immediate Cause (Final Immediate Cause (Final Onset and Death Physician/ ementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events the burial-tran attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Tes 2 No 3 Probably 4 M Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completely filled in by the funeral director, pag Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Excertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Heal State Registrar  State of Maryland / Department of Heal Certificate of Dear	,	giene Reg. No. 2012	40279
F	Physicia	n/	1. Decedent's Name (First, Middle, Last)	2. Date of Do Month	Day Year	3. Time of Death  3. Time of P M
	Medic Examin		Reva Criss  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Locat		4c. County of Dea	- 313
and I			Baltimore Washington Medical Center Glen Burni 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Un	ie Jnder 24 Hrs. 8. Date of Bi	Anne Art	
	uneral irector		408-36-8277 1 □ M 2 🛭 F	ours Min. (Month, Da	ay, Year) Co	thplace (State or Foreign buntry)
P.	how	'n	Usual Residence of Decedent 86  10a. State 10b. County 10c. City, Town or Location	11/15,	/1926   NO	rth Carolina  10d. Inside City Limits
Maryla	28a-f s	rect	MD Anne Arundel Severn			1 ☐ Yes 2 🎛 No
th the	3a or 2 t be no	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
eath wi	tems 2	-une	769 Tobbin Court  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispania If Yes, specify Cuban, Mexical Status	nic Origin? (Specify Yes or No	U.S.A.	erican Indian,
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ylan Mental	arked atjc ev	၀		Idela Mi	ller	
Reva Criss Baltimore, Maryland Permit Page 1 and 2 should be filed	or result and western to typere:  other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Donna Hatfield / Daughter  769 Tobbin Court			p Code)
Reva timore, M	f item		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	Town, State
Retirment Page	tant: I		4 Donation 5 Other (Specify)  Anatomy Gifts Registry	12/10/2012	Hanover, M	aryland
<b>Bal</b> permi	Important: If if any injury or o			Facility Anatomy Ley Dr., Ste.		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.			Approximate Interval Between
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60 ife be	© ≥ ≥	by Physician/Medical	La Dehydration sepsis			
<b>687</b> ertifica	iding p	υ/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	aliven.
<b>Box</b>	been signed by the attending ph should be detached for use as th	sicial	in the past 12 months?  1		Month	Day Year
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ds, F	en signe	ed ba		1 🗆	Yes 2 ⋈ No 3 ☐ F	Probably 4 🗆 Unknown
COrc	has bee	Completed		24a. Was	psy prior to	ntopsy findings available completion of cause of
I Re	certificate has bilirector, page 2 s		25. Was case referred to medical 26. Place of	1 ☐ Yes		s 2 No
Vita	000	To Be	examiner?  1  Yes 2 No	□ Nursing Home 5 □ Res	idence 6 🗆 Other (Spe	cify)
n of	After thi funeral	cate:	27. Manner of Death  1 🕅 Natural 5 🗆 Pending 2 🗋 Accident Investigation  28a. Date of injury (Month, Day, Year)  28b. Time of injury 28b. Time of injury 38b. Time of injury 48b. Time of injury 4b. Time of injury	_ [	how injury occurred	
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death.	To the Funeral Director: After completely filled in by the funer	Certificate:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined  5 ☐ Could not be determined		Street and Number or Ru wn, State)	ıral Route Number,
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e in	<b>2</b> 8		29b. Signature and title of certifier  MK House ACNP-BC 3192  R 10"1S		29d. Date signed (Mont	
	$\phi$		MK House ACNP-BC 3192  R1075  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  May Kim House ACNP-BC 301 Hospital Dr	r. Glen Bur	nie MD =	21061
ı	Stat Registra	e ir	31. Date filed (Month, Day, Year)  DEC 1 3 2012  Server S. Signature  G. Facilitation	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Denino Medical 4a. Facility Name (if not institution, give street and number) **Examiner** County of Death Medical Cin Anne Mnna DOG mund Social Security Numbe If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min. (Month, Day, Year) Director 513-70-7024 64 1 M 2 TH 09/01/1948 Italy Usual Residence of Dece i Hygiene. I other than "natural", or items 23a or 28e-f show vent, ite Medical Evanniner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1860 Quebec Court 21144 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Graphic Designer Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o Cenciotti Agostino Dorodea Federici 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Claude Federici / Son 1602 Huntcliff Way Gambrills, MD 21054 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) eny injury or conce. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/13/2012 Atlantic Crematory 4 Donation 5 Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service License MO1479 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final and Death Kespiratori Priysiciani disease or condition resulting in death) Medical Due to (or a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine consequence of) attending physician and ifor use as the burial-transit Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day the a 9 Unknown 9 Unknown s been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death. eral Director: After this certificate has I filled in by the funeral director, page 2 s autope performed : 2 No 1 Yes 2 No the Hospital or Attending Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မြ 1 Tes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 SNatural injury 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined hours after To the Hospital within 24 hours a To the Funeral Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sign 31. Date filed (Month, Day, Year) State Registrar

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edica	al Exami		MARK X . C	ROCAMO	(mhor)		4b. City, Tow	n orlo	action of F		Month December	9, 2012 Year		2133 hrs
			Baltimore Washington	. •		ľ	Glen Bu	•	cation of t	Death		Anne Arun		
	Funeral Director			6. Sex	7. Age (In yrs. I		If Under 1 Months	Year Days	If Under 2	24Hrs. Min.		(MM/DD/YYYY) 9	oreign	
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	Any		10a. State 10b. County		10c. City	Town or Locati	on	-					10	d. Inside City Limits
	land f show	ō		Arunde1		Linthic								Yes 2 X No
	Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Lut: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at noce.	Director	10e. Street and Number 436 Hawthorn	e Road			10f. Zip Co		090		10	g. Citizen of What United		
	ms 23a be noti		11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13. Wa	s Decedent of es, specify C	of Hispai	nic Origin	? (Spec	ify Yes or No-	14. Race - A	merican	Indian, Black,
	or death	Funeral	1 Never Married 2 Ma 3 Widowed 4 X Div	Armed F 1 Yes orced If Yes, Giva Yas	2 X No		Yes 2 XX		·	чепо кі	can, etc.)	White, e		
	irs aft	by	15. Decedent's Education (Spec	or Dates:		16a. Deceden				nd of wor	k done	Specify: 16b. Kind of Busine	Whi ess/Indu	
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215-0036	permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that injury or other traumatic event, the Medic.	ошр	17. Father's Name (First, Middle,		yrs.	P	ostmar		Mother's I	Nama /E	iret Middle M	aiden Surname)	aı s	ervice
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Baltimore,	es l ar of Hez If ite		20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal fr	om State	Place of Dispos crematory or oth	ner place)					20c. Location - Cit		
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Box 68760	leath certificate be attending physic for use as the bur	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in th		outcome of preg		tal death	3	Ectopic p	reananc	~	23d. Date of de Month	ivery Dey	Year
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P.O.	ires that th signed by I be detach	d by	Chronic Alcoholism				, ,				1 Yes	2 No 3	Probabl	y 4 🗹 Unknown
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Division of Vital	s after of Direct of in by	Certification:	3 Suicide 6 Coul		ce of Injury - At h	ome, farm, stree	et, factory, of	fice buil	ding, etc.	28	8f. Location (S or Town, St		r Rural I	Route Number, City
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Ce	1-11-011 0111)	nysician: To the bearing	st of my knowled of examination e	-								ause(s)
	Th wit	Mec	29b. Signature end title of certifie	end manner s	stated.		29c. L	icense n	number			29d. Date signed	(Month,	Day, Year)
						n	C	D.C.M.	Ε.			December 10	, 2012	2
	101		30. Name and eddress of person Russell Alexander MD	·	se of death (Iten		W. Baltim	ore S	treet, B	altimo	re, MD 212	23		
	Sí Regis	tate trar	31. Date filed (Month, Day, Year)		egistrar's Signat	for Kal	,				<u> </u>	• **		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ J. Carron 1:25 Desmond 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 039-22-8943 Director 1 🛛 M 2 □ F 79 April 30, 1933 Ireland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20814 10541 Farnham Drive United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ۾ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, filed within 72 al Hygiene. d other than " Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Statistician/Computer Expert Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental For them 27 is marked of fitem 27 is marked of other traumatic events 2 James Carron Muriel Hyland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Rose Carron / Wife 10541 Farnham Drive, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December permit. Page 1 a
Department of H
Important: If ite
any Injury or ot
once. 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery 14, 2012 Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Licensee Robert A. Fumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Markette Bankus M01305 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Glioblastoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physiclan and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Lause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 2 No signed by the e Yes g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 X No this certificate has ral director, page 2 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 M Other (Specify) Hospice 2 🔀 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours efter death.

To the Funeral Director: Aff completely filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, CRNP

31. Date filed (Month; Day, Year)

CRNP

6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Culler December ľď. 11:30 AM Betty Marie Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Center Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Hours Min. Director |500-24-2484 1 M 2 X F May 13, 1927 Kansas Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 299 Hurley Avenue 20850 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 l and Mental Hygiene. Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry Lewis ige 1 and 2 should be nt of Health and Men t: If item 27 is marke Lucille Lavina Mohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara Jo Culler / Daughter 6030 California Circle #106, Rockville, Maryland 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. permit. Page 1 a Department of H Important: If iter 20c. Location - City or Town, State December 1 Burial 2 X Cremation 3 Removal from State Injury or 4 Donation 5 Other (Specify) 13, 2012 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Funphrey Tuneral Home/Bethesda-Chevy Chase, Inc. any M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition en Medical resulting in death) Due to (or as a co Examiner SVCA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ē Due to (or as a consequence of): the attending physician and thed for use as the burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day signed by the at Id be detached fo 5 Other (specify) 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 헏 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

No the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy perform 2 N 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 □ only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of der ific 29d. Date signed (Month, Day, Year) 00057574 ((o((多 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Ahmed Heshmat, M.D.

**DEC 13** 

32.

2012

31. Date filed (Month, Day, Year)

2401 Research Boulevard Suite 330, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40284 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12/09/2012 Philip L. Clash 3:00p Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Ctr Harford Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours Min. 01/08/1955 219-62-0962 Director 1 XM 2 □ F 57 MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Aberdeen MD Harford 1 Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 508 Eastern Court 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Black Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3yrs 101-1500 Elementary/Secondary (0-12) Licensed Practial Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip Clash Hattie Clash 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda L. Clash Wife 508 Eastern Court Aberdeen MD 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 12/14/12 Glen Burnie MD 4 Donation 5 Other (Specify) Signature of Ameral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 SUPERIOR Immediate Cause (Final Physician/ disease or condition DAYS Medical resulting in death) Due to (or as a consequence of): Examiner THROMPOSIS 3N00 WEEKS Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Completed by Physician/Medical **Hospital or Attending Physician:** The law requires that the death certificate be east hours after death. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed certificate 1 ☐ Yes 2 ☐ No 2 2 N 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ You of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours area.

The Funeral Director, After this contact of filled in by the funeral director. ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural injury 5 Pending Division work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MD D00 72 DECEMBER, 09, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARKANDAYA UPPER CHESAPBARE DRIVE, BBLAIR, MO21014 MANJUNATH 32. Registras Signa 31. Date filed (Month, Day, Year)

OFC 1 3 2012 State Registrar

2012

-December

DOD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physici		- For State Certificate of	of Death	Reg. No	2012	4021
		1. Decedent's Name (First, Middle,Last) Nancy Irene Durham		Date of Death  Month Day  December 11,	Veer	ne of Death 49 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death	
		9400 Coastal Highway Unit 205	Ocean City		Worcester	-0:-
Funeral Director			If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	10/10/19	1/DD/YYYY) 9. Birthplace Foreign Country)	Maryland
' any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	ation		1 _	nside City Limits
Maryland 28a-f show d at ooce.	to	Maryland Worcester Ocean Cit	J	l a a		Yes 2 No
Haltmore, MIU Z1Z15-UU36 permit. Pages I and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importane: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic eveot, the Medical Examiner must be notified at occe.	Director	10e Street and Number 9400 Coastal Highway Unit 205	10f. Zip Code 21842	10g. Ci	tizen of What Country?	
leath with items 2.	Funeral		Vas Decedent of Hispanic Origin? ( Spec Yes, specify Cuban, Mexican, Puerto Ri		14. Race - American Ind White, etc.	dian, Black,
after c	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:		Specify: white	
hours "natu			ent's Usual Occupation (Give kind of wor most of working life. DO NOT use retired		Kind of Business/Industry	/
Mental Hygiene.  marked other than c eveot, the Medical	Completed		tant Manager	Co	ondo Buildin	g
Hygie I other		17. Father's Name (First, Middle, Last)	18.Mother's Name (F		n Surname)	
Mental Marke eveot,	To Be	Julious A. Sommers  19a. Informant's Name/Relationship (Type, Print)  19b. Mailii	Bertha Wi ing Address (Street and Number or Ru		Tity or Town State Zin C	odo)
Pages 1 and 2 should be filed within 72 hou ment of Health and Mental Hygiene.  taot: If item 27 is marked other than "nat or other traumatic eveot, the Medical Exa	F	Dennis Durham/husband 9400 (	Coastal Highway,Unit205	Ocean City	,Maryland 2184	<b>.</b> 2
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permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify.	ematory, Inc. 12/1			-
permit. Departr Importinjury	Į,		Name and Address of Facility Crema 99 Frederick Road			
hysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.			nock, or heart App	roximate Interval ween Onset and
Medicul Examiner		Immediate Cause (Final disease a. Cardiomegaly				Death
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	iner	Sequentially list conditions, but any leading to immediate cause. Enter Underlying Cause				
	Examiner	(Clesses or injury that hittiated events resulting in death) Last  Due to (or as a consequence of):				
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ate be execut hysician and e burial - tra	Medical	IF FEMALE:    AMENDED 23a, 27, per me,			3d. Date of delivery	
tifical ng ph	an/N	3b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnanc		Month Day	Year
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at the death cert I by the attendir tached for use a	Physician/I	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cau	use of death?
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P. Wilt	Medical Certification: To Be Completed by	25. Was case referred to medical examiner?  1	26. Place of Death (Check on ont 3 DoA Other Mursing of Injury 28c. Injury at Work?  1 Yes 2 No reet, factory, office building, etc. 2 curred at the time, date and place, and digation, in my opinion, death occurred at t	1  Yes 2  24a. Was an autopsy performed?  1  Yes 2  Yes Yes 2  Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	No 3 Probably  24b. Were autopsy f prior to complet death?  No 1 Yes  lence 6 Other: Scenary occurred  and Number or Rural Round manner as stated.  lace, and due to the caus.  Date signed (Month, Date)	4 Unknown indings available ion of cause of 2 No a  ute Number, City e(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dec. Day 2012 6:35рм Robert Milton Dickerson, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster 5. Social Security Number 9. Birthplace (State or Foreign Country)
Delaware 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days (Month, Day, Year) Director 221-26-9908 1X□ M 2 □ F Aug. 20,1941 Usual Residence of Decedent 2 should be filed within 72 hours efter death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23e or 28a-f show treumetic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🌠 No Maryland Sykesville Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 U.S.A. 5901 Hanna Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Social Security Computer Programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Helen Aliene Johnson Alfred Clarence Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) end 2 s Health a 5901 Hanna Rd. Sykesville, MD. 21784 Kelli Creighton - daughter item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pege 1 e
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State South Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Harth Esland? 21102 3296 Charmil Dr. Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-trensit The lew requires that the death certificete be executed end resulting in death) Last Due to (or as a consequence of): ettending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ō in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 9 Unknown ate has been signed by the e page 2 should be detached 2 No not resulting in the underly, Part II. Other ignificant conditions contributing to death b ause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate 1 ☐ Yes 2 ☑ No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Officer (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suícide
4 Homicide within 24 hours after death

To the Funerel Director: A
completely filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Registrar DHMH 17 Rev 06-2011

State

IDV

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC 1 3 2012

Name and

2. Registrar's Signati

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Richard D. Davis 3:15 P M December 10, 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 442 Spry Island Road Harrford Jappa 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 24,1949 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Hours Lyndawille, VI 008-34-7189 Director 63 1 DXM 2 D F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Markel Examiner must be notified. 10h Counts 10c. City, Town or Location 10d. Inside City Limits Director Fairfield Danbury 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 06811 United States 19 Jackson Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dennis Davis Nylene Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Jackson Drive Danbury, CT 06811 Sally Davis- Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December Evans Funcial at 1 ☐ Burial 2 🏻 Cremation 3 ☐ Removal from State Forest Hill, MD 4 Donation 5 Other (Specify) 13, 2012 Bel Air Signature of Funeral Service License 22. Name and Address of Facility Chapel & Cremation Services 8800 Harford Road Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastahe pancreas cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burlal-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 687 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Daughter's 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year)

Division of Vital

State Registrar

82. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jakell, M.D

Dan Lahere

D53070

1650 ofleans St Room 4mog Balhmore, MD 2/287

Dec 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Dunboraw December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death rs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours Director 217-56-1946 1 M 2 X F Yrs 03/22/1951 61 Maryland Usual Residence of Deced and Mental Hygiene.
Is marked other than "natural", or items 23a or 28e-f show marked other than "natural", or items 23a or 28e-f show reumatic event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28e-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 811 Maryland Avenue U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes. Give Specify 3 X Widowed 4 ☐ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Κ. Carter Mary Carmen Koetzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Maryland Avenue, Hagerstown, MD 21740 Troy Carter / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Importent: If its any Injury or of once. ŏ 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 12/12/2012 Hanover, Maryland 21. Signature of Funeral Service Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ischemic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗌 No 1 U Yes **Division of Vital** æ 25. Was case referred to medical 26. Place of Death (Check only one) <u>ا</u> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 🗆 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending s after death. I Director: Aft 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral D Hospital Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier

Registrar

State

60 Ortean

2118

Many

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

324 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40289 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Day 0, Physician/ 2012 7:30a M Margaret Donoian Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Chevy Chase 4242 East-West Highway, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Director 577-42-4275 1 🗆 M 2 🗓 F 82 April 18, 1930 Massachusetts 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location ns 23a or 28a-f show 10b. County Director 1 ☐ Yes 2 🛛 No Chevy Chase Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral Paga 1 and 2 should ba filad within 72 hours aftar daath with ' nant of Haalth and Mental Hyglana. 20815 4242 East-West Highway, #511 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Telecommunications College (1-4 or 5+) Elementary/Secondary (0-12) Contract Administrator Corporation is marked other aumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Ashken Arslanian Armenak Shahian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12752 Turquoise Ter., Silver Spring, Maryland 20904 f Haalth item 27 other tra Janet Donoian Kearns/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Paga 1 Department of Important: If it any injury or of once. 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 12/14/2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attanding physician and for usa as the burlal-transi that initiated events resulting in death) Last Due to (or as a consequence of) Medical Certificate: To Be Completed by Physician/Medical If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Day in the past 12 months?

Hospitai or Attending Physician: Tha law raquiras that tha daath cartificata be axecuted Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law raquiras that the das within 24 hours after death.

To the Funeral Director: After this cartificate has bean signed by the a completely filled in by the funeral director, page 2 should be detached

1 ∐ Yes 2 LANo 9 ☐ Unknown	9 Unknown	
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? = 1 💆 Yes 2 🗆 No 3 🗀 Probably 4 🗀 Unknown
		24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2  No
25. Was case referred to medical	26. Place of Death (Chec	k only one)
examiner? 1  Yes 2  No	Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 K Residence 6 ☐ Other (Specify)
27. Manner of Death  1 X Natural 5 Pending 2 Accident Investiga		28d. Describe how injury осс <i>и</i> теd
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 X Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as stated.  at the time, date and place, and due to the cause(s) and manner state

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

December 11, 2012

State Registrar

only one)

29b. Signature and title of ce

2101 Medical Center Drive, #200, Silver Spring, MD 20902 M.D., Kashif Sirozvi. 31. Date filed (Month, Day, Year) 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State		State	of Ma	ryland / Do	epartme Certifica			and M		giene Reg. No.	20	12	IιΩ	290
			Registrar  1. Decedent's Name	(First, Middle,	Last)			<del>Jorano</del> a.	0 01 2			2. Date of Dea		20	1-	3. Time of	f Death
	Physicia	1/			1 100	Fuge	ne Deppert					Month 12	Day 1 (		Year 2012	8.2	5 AM
-	Medic Examin		4a. Facility Name (if	not instituti <b>o</b> n,			пе Берреге		, Town, or	Location o	f Death			County of			
	Examin	<del>-</del> 1	_	ice Garde						Caton	sville				Balti	more	
	Funeral		5. Social Security Nu		6. Sex	_	(In yrs. last birtho	ay) If Und Months	er 1 Year Days	If Under 2		8. Date of Birt	h v Yearl		9. Birthp	olace (State o	or Foreign
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	, M		Usual Residence o	f Decedent 10b. County			10c. City, Town o	r Location							1	I0d. Inside C	ity Limits
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	ath w	Funeral	11. Marital Status	ich Choice	12. Was Dec	cedent Ev	er in U.S.	13. Was Dec	edent of H	ispanic Orio	in? (Spe	ecify Yes or No-			- Americ	can Indian,	
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2	Hygla Hygla ther	Be	17. Father's Name (			5+				18. Moth	er's Nam	e (First, Middle,	Maiden :		ccour	ning –	
and	intal k	P	Tr. Facility	, ,, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Harry D	lennert	•						ertie I				
2	mari meti		19a. Informant's Na	ame/Relationsh		сррсп		Mailing Addre	ss (Street	and Numbe	er or Rura	al Route Numbe			ate, Zip	Code)	
Š	12 sh lith ar 27 is r trau		Susan Depp	ert Hutto	n / Daughter			19 Old G	ranary	Court,	Caton	sville, MD	2122	8			
re,	T and Item		20a. Method of Dis		•□• ===================================	- 04-4-	20b. Place of	Disposition (N crematory of	ame of other pla	ce)		Date	20c. Lo	ocation - (	City or To	own, State	
Ë	Paga nant c ant: if		1 ☐ Burial 2 4 ☐ Donation		3 ☐ Removal fro pecify)	m State	i	ipeake Ci			12/1	1/2012		Beli	tsville	e, MD	
Baltimore, Maryland 21215-0036	parmit. Paga 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mantal Hyglane. Importent: if item 27 is marked other than "netural", or items 23e or 28s-f show eny injury or other traumetic event, the Medical Evaringer must be notified at 20ce.		21. Signature of Fu	neral Service L	_	, (	ا برا ا		and Addre	ss of Facilit	ty						
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				rt failure. List o	complications that only one cause on	each line.										Interval Be	etween
	Physician/		Immediate Cause disease or condition resulting in death)		_ a. AH	_	sclerat		-dio	VASC	ula	dise	ese		-		
Y.	Medical Examiner		resulting in docting		Due	o (or as a	consequence of	):									
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	ata ba executed physician and the burial-transit	dical Examiner	Cause. Enter Under Cause (Disease or that initiated even	injury											_		
	Attending Physicien: Tha law raquiras that the daath certificata ba executed ar daath. ector: Aftar this cartificate has baan signed by the attanding physician and by tha funeral director, paga 2 should ba datached for use as tha burial-trans	Ĕ	resulting in death)		Due 1	to (or as a	consequence o	):							ŀ		
9	ta ba nysici ha bu				d												
687	rtifica ing pl	Ž	IF FEMALE:		23c If yes	outcome (	of pregnancy							23d. Date	o of doli	100	
Box 6	th ce ttand for us	lan	23b. Was deceden in the past 12	months?	1 🗆 🖰	ve Birth	2  Fetal death t time of death	3 🔲 Ectop 5 🔲 Other	ic pregnan	псу				Mor		Day	Year
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ğ	ding Phy h. Aftar thi funeral	ë	27. Manner of Dea Natural	ith 5 ☐ Pendi	4	ate of inju fonth, Day		ime of jury	28c. Inju	rk?	٦.,	28d. Describe	how inju	гу оссите	ed		
ö	uttendi daath. ctor: A y tha fu	Įĝ	2 ☐ Accident 3 ☐ Suicide	Invest 6 ☐ Could	not be	an of lair	ury - At home, fa	M street fac		Yes 2		28f. Location	(Street ar	nd Numbe	er or Rur	al Route Nu	mber.
Division of Vital Records,	or At after o	Certificate:	4 Homicide	deterr			c. (Specify)	iii, street, lac	iory, omice	•			wn, State		,, 0		,
Δ	To the Hospitei or Attenwithin 24 hours aftar deat within 24 hours aftar deat to the Funeral Director: complataly filled in by tha	Medical	(Ohaali	2 Madical	g Physician: To the Examiner: On the g Nurse Practitio	hacie of a	vamination and/o	rinvestigation	in my onir	nion death d	occurred	at the time, date	and Diac	e, and due	e to the c	ause(s) and r	manner stated
	To the within To the compl	2	29b. Signature and	d title of certifie	er	-			29c. Licen	se number			29d. Da	ate signed	d (Month	n, Day, Year)	
					Butterns				1408	723	7 4		12	-10	1-1	<u>_</u>	
T			30. Name and add	dress of person	who completed of	ause of d	leath (Item 23a) (	Type, Print)	Lean	hoico	10-	. Ba	lto	Ma	12	1228	Š
$\lambda^{\times}$	\		31. Date filed (Moi	nthe Bave Year		2. Parietr				4000	CM		0 ,				
,	St: Regist	ate rar	3		3 2012		1. 1	har	1								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40291 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ December Day 240PM Dernard 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Jown, or Location of Death 4c. County of Death pital Bultimur SINGI 1+05 Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 220-20-0143 Director 1 M 2 🗆 F 82 Usual Residence of Decedent permit. Pege 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Importent: If item 27 is merked other then "neturel", or items 23e or 28e-f show eny injury or other treumetic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3502 21215 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🗷 No 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 2 Sollege (1-4 or 5+) (Give kind of work done during most of working life DD NOT use retired) Elementary/Secondary (0-12) aims ueurs Be 17. Father Name (First, Middle, Last) ည 19a. Informant's Name/Pelationship (7 City or Town, State, Zip Code) 19b. Mailing Address (Street and Number on Rural Route Num Patient Ball-more, onna torc Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or ether) 20a. Method of Disposition 1 Y Burial 2 Cremation 3 Removal from State lwings Mills. 4 ☐ Donation 5 ☐ Other (Specify) zamson Funeral Services 21. Signature of Fune al Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ESRI Medical resulting in death) Due to (or as a consequence of): Examiner CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Fibrillation been signed by the ettending physicien end should be detached for use es the burlel-trensit Atrial To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the ettending physicien end Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Heart Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tor: After this certificate hes the funeral director, page 2 autopsy performe 1 Yes 2 No Yes 2 🔀 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 6 \( \subseteq \text{Other (Specify)} \) 1 ☐ Yes 2 X No ဂ္ Nopatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be within 24 hours after de To the Funerel Directo completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bassi Sinas 31. Date filed (Month, Day, Year) 32. Registrar's Signatur 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

evin L Freeman		State of Maryland / Department of Health and Mental For State  Certificate of Death	Hygiene	Dog A	20	12	4029
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of			З. Т	ime of Death
Medical Examin		Kevin L. Freeman	Month Decem		2012		1806 hrs
		4a. Facility Name (if not institution, give street and number)  Good Samaritan Hospital  4b. City, Town, or Location of Dea Baltimore	ath		4c. County of I	)eath	
Funeral	٩	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	Irs. 8. Date o	f Birth (M	IM/DD/YYYY)	9. Birthpla	ce (State or
Director	- 1		1in. 6-	-11/2-	1961	Foreign Country	MD
	-	Usual Residence of Decedent		10	1141		
W A O O		10a. State 10b. County 10c. City, Town or Location					I. Inside City Limits
Maryland 28a-f show 1 at once.	اق	MD 10e. Street and Number 10f. Zip Code		1	-1.1	,	Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director			10g. (	Citizen of What	Country?	
ith the	_	5 639 An Hony Avenue 3 13-0 ( 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (		r No-	14 Race -	American	Indian, Black,
eath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No			White,		main, bigor,
after d	및 교	3 Widowed 4 Divorced If Yes Give Year or Dates:			Specify:	3/4	cK
hours		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re		161	b. Kind of Busir	ness/Indus	stry
36 in 72 han "		Elementary/Secondary (0-12) College (1-4 or 5+)			Div	ate	
21215-0036 Muld be filed within 7 Mental Hygiens marked other than c event, the Medical	Completed	17. Father's Name (First, Middle, Last)  Homema Ker  18. Mother's Name	me (First, Mide	dle, Maid		110	
21215-00 uld be filed wit Mental Hygien marked other c event, the M	Be	Melvin P. Freeman Pegg	VN	7. 1.	Bake		
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 77 is marked other than "natural", or items 23s or 28s-fahnatic event, the Medical Examiner must be notified at once	유	Informant's Name/Relationship (Type, Print )	/	-		-	
alth 2	-	Patricia V. Treeman / Witc. 5639 An Thony At 20a. Method of Disposition (Name of cemetery,	VLNVL,	/34	C. Location - C	ity or Tow	1) 2/2 06
Baltimore, MD 21215-0036 sermit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than a jury or other traumatic event, the Medical		1 Rurial 2 Cremation 3 Removal from State crematory or other place)	-		1	•	
Baltimo permit. Page Department Important: injury or other	-	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Val	-13-201	2/	tanov	er 1	VID
Balt permit. Depart Impor		MU (6/25 4905 YOCK R 20	ight Ba	11:	MOVE W	10 21	212
Physician	$\dashv$	23a. Part/Enter the disease, or confplications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each life.	c or respirator	y arrest,	shock, of heart	A	pproximate Interval
/Medical :xaminer		Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiov	ascula	r Di	sease		Death
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-	or condition resulting in death)  Due to (or as a consequence of):					
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
1	티클	C. (Disease or injury that initiated expents resulting in death). Last				_	
	۱۵	events resulting in death) Last Due to (or as a consequence or):  d.					
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760 cate b	Š.	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of de		
certification and ing	San	23b). Was decedent pregnant in the pest 12 months?  1 Live birth 2 Fetal death 3 Ectopic preg 4 Pregnant at time of death 5 Other (Specify)	gnancy	4	Month	Day	Year
Box 6876  e death certificate the attending phy ed for use as the I	Physician/M	1 Yes 2 No 9 Unknown		-			
P.O. Box 6876: ss that the death certificate gred by the attending phy te detached for use as the 1	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				_	cause of death?
ords, P.C. w requires that s been signed should be deta		<u>Diabetes Mellitus</u>	- 1				4 V Unknown
cords law requi	름		_   4	Vas an autopsy performed	prid		y findings available eletion of cause of
Rec The li cate h	Completed			es 2		Yes	2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital:   Inpatient 2 FR/Outpatient 3 DOA Other   Nurs				20	
Division of Vital Records, tallor Attending Physician: The law requirers for each.  In Director: After this certificate has been side; in by the funeral director, page 2 should be.	의	1 Ves 2 No rospital I Inpatient 2 V ER/Outpatient 3 DOA Outer 1 Nurs  27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	rsing Home 5		injury occurred	Other:	
on of anding Ph ath.	<u></u>	1 X Natural 5 Pending (Month, Day,Year) 1 Yes 2 No					
Vision or Attent or Attent ler ceath Director: in by the	<u> </u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.				or Rural F	Route Number, City
D pital ours	Certification:	4 Homicide determined (Specify)	orio	vn, State	')		
	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.					use(s)
# 3 # 8	\$	29b. Signature and title of certifier 29c. License number		29	d. Date signed	(Month,	Day, Year)
		O.C.M.E.			ecember 9	, 2012	
		30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Balt	timore, MD	21223	3		
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		UGME	-		
Registi	ar	31. Date filled (Month, Day, Year)		W 70' 1.			

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006 FINNE GAN, HELEN MARGARET Baltimore, Maryland 21215-0036

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			Registrar  1. Decedent's Name (First, Middle	e, Last)		061	incate or i	Death	- T	2. Date of Death	g. No.	14	3. Time of Death
	Physicia Medic	al	HELEN MARGARE	T FINNE						DECEME	ER 10	20/2	~
and a	Examin	er	4a. Facility Name (if not institution	_			4b. City, Town, o				4c. County	of Death	MADE
	Funeral		SAINT TOSE  5. Social Security Number	6. Sex	7. Age (In yrs.	ast birthday)	If Under 1 Year	USO/ If Under	24 Hrs.	8. Date of Birth	1 /2/7	9. Birthp	place (State or Foreign
	Director		216-48-2396	1 □ M 2XXF	93	Yrs.	Months Days	Hours	Min.	(Month, Day,		Count	,,
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	arylan a-f sh fied a	Director	Maryland Baltin			vson	cation					1	1 ☐ Yes XX No
	or 28		10e. Street and Number	loi e	100	V30(1	10f. Zip Code	-		1	Og. Citizen of V	What Coun	
	s filed within 72 hours after death with the Maryland tal Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medicel Examiner must be notified at	Funeral	615 Chestnut Avenue	<del>- ,</del>			2120				US		
	r deat		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Mar</li></ul>	12. Was Dece	edent Ever in U. prces? 2 ZANo	S. 13. \	Nas Decedent of H f Yes, specify Cub	lispanic Orig an, Mexicar	gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		e - Americ k, White, e	
336	s after al", o Exam	d by	3 Widowed 4 □ Divorced	16 V O:-	ve	1	l ☐ Yes 2 <b>XX</b> No	Specify:	:		Specify:	lub	ite
2-0	hour hatur dicel	Completed		nt's Education est grade completed		16a. Deced	dent's Usual Occup kind of work done	pation	t of working	. 1	16b. Kind of Bu		
2	hin 72 ne. <b>than</b> "	Ē	Elementary/Secondary (0-12)	College (1		life. D	O NOT use retired,	)	t of working		Own 1	iomo	
72	led within Hygiene. other tha ent, the N	BeC	17. Father's Name (First, Middle, I	l acti		Homema	aker .	40.14-44	anda Niama	(Einst Adiodolo Ad			
Śaltimore, Marylańd 21215-0036	uld be file Mental H narked o	일	Julian William Morn	•				18. Moth		(First, Middle, M 11e McCun		*)	
lary	shou and is m		19a. Informant's Name/Relations	hip (Type, Print)			ng Address (Street				•	tate, Zip C	Code)
e)	1 and 2 if Health item 27 other tr		Dennis E. Finnegan 20a. Method of Disposition		Son		lala Court	limoni					21
Jou		П	XX Burial 2 ☐ Cremation		State	cemetery, cren	natory or other pla National Ce	metery		I .	20c. Location - altimore	•	·
<u>ij</u> .	permit. Page Department of Important: If any injury or once.		Donation 5 Other (S		/ :		. Name and Addre						
, M	Per Opp any		Dennis Du	un Ken	NRIS					ore, Mary			OIL THE
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that	caused the dea	th. Do not ente	er the mode of dyi	ng, such as	cardiac or	respiratory arres	st,		Approximate Interval Between
-	nysician/	ì	Immediate Cause (Final disease or condition resulting in death)	_a. My	OCAR	DIAL	INFAI	RCTI	ON				Onset and Death
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760	ate br physic the b	edic		d									
189	sertific ading ase as	Ž	IF FEMALE: 23b. Was decedent pregnant		tcome of <u>pr</u> egna		_				23d Da	te of delive	en/
Box 6876(	leath of for I	sicia	in the past 12 months? 1  Yes 2 No	4 Preg	gnant at time of		☐ Ectopic pregnan ☐ Other (specify) _	ю				nth	Day Year
P.O. E	is that the death certificate tigned by the attending physise detached for use as the	Physician/Medi	9 Unknown  Part II. Other significant condition	9 Unk		sulting in the u	inderlying cause a	ivon in Port		00- Di II-I			ne cause of death?
s, P.	Attending Physician: The law requires that the death certificate are death. ector attent. ector atten this certificate has been signed by the attending physby the funeral director, page 2 should be detached for use as the	Completed by	ACUTE REA				inderlying cause g	iveii ii Fait	·	23e. Did tob			pably 4 Unknown
ord	w requires s been sig	olete	METABOLI							24a. Was an			osy findings available
Rec	sician: The law i certificate has b lirector, page 2 s	Som								autops perform	ned?	death? ∐Yes	mpletion of cause of
<u>la</u>	cian: ertifici ector,	Be (	25. Was case referred to medical examiner?	Hospital:				Place of Dea	th (Check	only one)			
ξ	Physi this o	2	1 ☐ Yes 2 💆 No 27. Manner of Death	1 X	Inpatient 2	ER/Outpatier	T 3 LI DUA			ne 5 🗆 Reside			)
0 1	th. th. After s fune	cate	1 X Natural 5 ☐ Pendir 2 ☐ Accident Investi	ng (Mon	nth, Day, Year)	injury	wor	ryat rk? ]Yes 2. □	- 1	8d. Describe hov	v injury occurr	ea	
Division of Vital Records,	er dea rector	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	e of Injury - At h		eet, factory, office			8f. Location (Str		er or Rural	Route Number,
Š	oital or urs aft eral Dir filled in	ğ								City or Town,			-
	To the Hospital or Attending Physician: "Thin's 24 hours after death after this certificator the Funeral Director. After this certificator physician in by the funeral director,	Medical	(Check 2 Medical E	g Physician: To the b Examiner: On the bar g Nyrse Practitione	sis of examination	on and/or inves	tigation, in my opin	ion, death o	ccurred at t	he time, date and	place, and due	e to the cau	use(s) and manner stated.
	To the within to the comp	~	29b. Signature and title of certie	1/1//		, , , , ,	29c. Licens				d. Date signed		
	,		6/10/	41100	>		D3	3118	9	2	cense	21/1	2012
	31		30. Name and address of person	who completed cause		n 23a) (Type, F	Print)	RA	RIUF	Toms	MI MI	ARUI I	2012 9ND 21204
	Sta		31. Date filed (Month, Day, Year)	32. [	gistrar's Signa	die de	a Ned	<u> </u>	~; 00	1000	<u> </u>	<u> </u>	11-17 00/000 1
	Registra	ar	TEC 1	<u> </u>	war.	p. 190							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar	-	artment of H			giene Reg. No. 2012	2 40294
	Physicia Medic		1. Decedent's Name (First, Middle, I					2. Date of Dea Month		3. Time of Death 2 11:00AM M
,	Examin		4a. Facility Name (if not institution, g			4b. City, Town, or	Location of Deat	h	4c. County of Dea	
/			607 Lycoming St 5. Social Security Number 6	reet Sex 7. Age (In yrs.	last hirthday	Silver If Under 1 Year	Spring If Under 24 Hrs	. 8. Date of Birth	Montgom	
	Funeral Director		435-28-4684	1 □ M 2 🛱 F	Yrs.	Months Days	Hours Min.	(Month, Day		irthplace (State or Foreign ountry)
	D W		Usual Residence of Decedent	91				August 1	.8,1921 Lo	ouisiana
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Director	10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	or 28a	Dire	Florida Broward	l Pa	rkland	10f. Zip Code			10g. Citizen of What C	
	with the 23a c	eral	6981 NW 70th S	troot		33067			United Sta	
	items er mu	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spanic Origin?	pecify Yes or No-	14. Race - Am	erican Indian,
36	after o	l by	1 Never Married 2 Marrie	1 ☐ Yes 2 🏋 No		Yes 2 X No		o nican, etc.)	Black, Whi	te, etc.
8	ours a atural cal Ex	Completed	3 X Widowed 4 Divorced  15. Decedent's	Year or Dates.		lent's Usual Occupa				White
215	72 h an "n Medi	mpl	(Specify only highest Elementary/Secondary (0-12)		(Give I	kind of work done d O NOT use retired)	uring most of wor	rking	16b. Kind of Business	s/Industry
21	iled within Il Hygiene. other thar		Elementary/Secondary (0-12)	4	Teac	her			Education	n
pui	e filed ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Na	me (First, Middle, I	Maiden Surname)	
7	should be file and Mental I is marked o raumatic eve	_	Samuel Benjamin  19a. Informant's Name/Relationship		T		Beuna			
Maryland 21215-0036	S = 2 +		Sharon Tanya Do Melanie Faith B		19b. Mailin				City or Town, State, Z	1
re,	1 and of Heal item		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date	d, Florida  20c. Location - City o	
mo	Page nent o ant: if ury or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 🎇 Other (Spe	Removal from State cify)Entombment Bo		natory or other place on Cemete		ember 2012	Boca Rato	n. Florida
Baltimore,	permit. Page 1 Department of 1 Important: If it any injury or of		21. Signature of Funeral Service Lice	Cult MOC	22 B 0335   B	Name and Addresethesda-Cethesda,	s of Facility Ro Chevy Cha Maryland	obert A. ase Inc d 20814-	Pumphrey 1 7557 Wise 3501	Funeral Home/ consin Avenue
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	replications that caused the dea one cause on each line.	th. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
~~ I	Medical		Immediate Cause (Final disease or condition resulting in death)	a. Coronary A		clerosis				Onset and Death
-1	Examiner	П	Toodking in dodkin	Due to (or as a consec	quence of):					
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):					
	uted nd ransit	Examiner	Cause (Disease or injury that initiated events	С.						
	e be executed ysician and ne burial-transit	al E)	resulting in death) Last	Due to (or as a consec	quence of):					
	ate be	edical		d						
Box 6876	certific oding I use as	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy				23d. Date of de	alivan
30X	eath o	icia	in the past 12 months?  1  Yes 2 No	1 Live Birth 2 Fet 4 Pregnant at time of		Ectopic pregnancy Other (specify)	y		Month Month	Day Year
O. E.	t the d by the tacher	Phys	9 🗌 Unknown	9 ∐ Unknown						
ls, P.O.	The law requires that the death certificate attending phy, page 2 should be detached for use as the	Completed by Physician/Med	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.		bacco use contribute t ′es 2 <b>X</b> No 3 □ 1	o the cause of death?  Probably 4 Unknown
Division of Vital Records,	aw req	plet						24a. Was a		utopsy findings available completion of cause of
	The la ate ha	Com						perfor		
ta	sician: The law i certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		- T	ce of Death (Che	ck only one)		Temporary
<u>&gt;</u>	Phys	2	1 ☐ Yes 2 X No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatien 28b. Time of	t 3 DOA Othe	4 ☐ Nursing F	T .	ence 6 X Other (Spe ow injury occurred	
o uc	nding ath. ; After e fune	cate	1 X Natural 5 Pending 2 Accident Investigat	(Month, Day, Year)	injury	work		200. Describe no	ow injury occurred	
isio	er dez ector	Certificate:	3 Suicide 6 Could no 4 Homicide determine	be 28e Place of Injury At h	ome, farm, stre	et, factory, office			reet and Number or Ru	ural Route Number,
<u> </u>	ital or urs aft ral Dir lled in		lle .					City or Towr		
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check 2 L Medical Exa	nysician: To the best of my know miner: On the basis of examinatio urse Practitioner: To the best of	on and/or invest	igation, in my opinior	n, death occurred	at the time, date an	nd place, and due to the	cause(s) and manner stated.
	To the complete compl		29b. Signature and title of certifier			29c. License			29d. Date signed (Mon	
			1 Glob	* WY		D3714	+2		December 10	0, 2012
	81		30. Name and address of person wh						1 00070	
	Stat		Geoffrey Coleman 31. Date filed (Month, Day, Year)	32. Februar's Signa		rive, Roo	ckville,	Marylan	a 20850	
	Registra		DEC 1 3	2012 June		wed				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		•	For State Registrar		State of M	arylan			ent of He ete of De		Mental Hy	giene Reg. N			
	Physicia			e (First, Middle, Last	FINKE	,					2. Date of De	ath	20 ay 10 2 Year	2 3. The of Death 9	7
	Medic Examin		4a. Facility Name (if	not institution, give				4b. Cit	y, Town, or Lo	ocation of Dea			c. County of De		
ممسيا				F PIKESVI			16.54.1.3		IKESVI	LLE f Under 24 Hr	- 1 - 5 - (5)			IMORE	_
	Funeral Director		5. Social Security N  220-35-  Usual Residence of	-5426 <sup>1[</sup>	х Дм 2 <b>Х</b> Г г 7. Адч	88	ast birthday) Yrs.	Month		Hours Mir				irthplace (State or Foreign country) RUSSIA	
	show dat	tor	10a. State	10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits	٦
	Mary 28a-f	irec	MD	BALTIM	IORE		OWINGS							1 ☐ Yes 2 🛣 No	
	ith the 23a or at be n	Funeral Director	10e. Street and Nur		"00"			10f. 2	Zip Code	1 7		10g. C	itizen of What C	Country?	
	ems 2	nne-	3440 AS	SSOCIATED	WAY, #305		S. 13. V	Vas Dec	211 edent of Hisp	anic Origin? (8	Specify Yes or No-		USA 14. Race - An	nerican Indian,	-
980	1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	1 ☐ Never Marr 3ሺ Widowed	ied 2  Married 4  Divorced	Armed Forces?  1  Yes 2 X  If Yes, Give Year or Dates.	No			ecify Cuban,		rto Rican, etc.)		Black, Wh Specify:	ite, etc. WHITE	
5-0	2 hour "natu edical	plet	(Spe	15. Decedent's Ec	lucation de completed)		(Give I	kind of w	sual Occupation	on ing most of wo	orking	16b.	Kind of Busines	s Industry	П
21215-0036	d 2 should be filed within 72 alth and Mental Hygiene. 127 is marked other than "rir traumatic event, the Med	Completed	Elementary/Sec	onday (0-12)	College (1-4 or 5	5+)	1		ise retired) ITANT		_		FOOD		
nd	filed v al Hyg d othe	) Be	17. Father's Name (	First, Middle, Last)					1	8. Mother's Na	ame (First, Middle	Maider	Surname)		
Maryland	uld be d Ment marke natic	인	PROKOP	/D.I.V. 12 /T.		IEREZ				ANNA				PEZMIKOV	_
Ma	2 sho Ith and 27 is I			ame/Relationship (Ty GORIN/DAU	,			-	,		ural Route Number T, BALTI	-		Zip Code) 21208	
ore,			20a. Method of Disp	position			Place of Dispo	sition (N	ame of		Date		Location - City		
Baltimore,	permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr once.		4 Donation	5 Other (Specify		1	R SINA	I CE	EMETERY		12/2012			MILLS, MD	_
Bal	permi Depar Impor any in		21. Signature of Fu	neral Service License	alles						OL LEVIN			=	
			shock, or hea	rt failure. List only or	lications that caused ne cause on each line	∍.			1			rest,		Approximate Interval Between Onset and Death	
ä	Physician/ Medical		Immediate Cause ( disease or condition resulting in death)		a. Due to (or as		ence of):	45,0	4 51	SEASE				0.1001 a.12 Doasi	4
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	cate be executed physician and the burial-transit		that initiated event resulting in death)	S I	c. Due to (or as	a consequ	uence of):				<del>-</del>				_
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687	eth certifica attending pl		IF FEMALE:		23c. If yes, outcome	of pregna	ancy	•					23d. Date of d	deliver.	
Box.	Hospital or Attending Physician: The law requires that the de. th certificate be executed 44 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and atted filled in by the funeral director, page 2 should be detached or use as the burial-transit	Physician/N	23b. Was decedent in the past 12 1  Yes 2 9  Unknown	months?	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3		c pregnancy (specify)				Month	Day Year	
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of Vital Records,	The law require cate has been sip page 2 should is	Completed by	DINBER	s NElli	tus_							psy ormed?	prior to death?		
al R	sician: The certificate I rector, pagi	Be Co	25. Was case referr	ed to medical					26. Place	e of Death (Ch	1 \(\sum \) Yes eck only one)	2 🛂	No 1 □ Y	′es 2 □ No	-
Vit.	Physici this cer al direc	10 E	examiner? 1  Yes 2	I No			ER/Outpatier				Home 5 Res	dence	6 Other (Spe	ecify)	
on of	ttending P death. stor: After t the funera	Certificate:	27. Manner of Deat  1 Natural 2 Accident 3 Suicide	h 5 ☐ Pending Investigation 6 ☐ Could not be			28b. Time of injury	M	28c. Injury a work? 1 ☐ Ye	t es 2 🗆 No	28d. Describe	how inju	ıry occurred		
Division	ital or Attencurs after death ral Director: , led in by the		4 Homicide	determined	28e. Place of Injubulg			eet, fact	ory, office		28f. Location ( City or To			Rural Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2	Medical Examination	ician: To the best of ner: On the basis of e e Practioner: To the	xaminatio	n and/or inves	tigation,	in my opinion,	death occurre	d at the time, date	and plac	e, and due to th	e cause(s) and manner state	d.
J	Vithi Vithi Comp		29b. Signature and	title of certifier				2	9c. License n	umber		29d. D	ate signed (Mor	nth, Day, Year)	
			20 Nama and add	acc of parent when	ompleted cause of d	leath (lea-	n 23al /Tima F	Print)	K088	077		250	FULFIL	-11 2012	_
			KANUS	NC. DIA	num &	P.o.	Box 26	13	Splis	Busy,	Maryl	ned	- 280	-11 2012	
	Sta Registr			h, Day, Year) 3: 2012	32. Registra	ar's Sig <u>n</u> a	ture	,							

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AMEND ITEM# 28a-1, perME.G937, 3/22/2013, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year 0023M Bryan Sinod Graham 2012 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Director 263-93-3608 1 🕅 M 2 □ F 43 Jan. 19, 1969 Florida Usual Residence of Dece 27 is merked other then "neturel", or items 23e or 28a-f show traumetic event, the Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Upper Marlboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7306 Perrywood Road 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is merked other then 'eny Injury or other traumetic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) 4yrs Manager Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Hardy Graham Sue Shell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherri Graham/Wife 7306 Perrywood Road, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lone Oak Cemetery 12/15/2012 | Leesburg, Florida 21. Signature Funeral Pervice Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 20 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ettending physician end I for use es the bunal-transi The law requires thet the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a nsequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the el 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physicien: The law within 24 hours after death.

To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2? autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 8 26. Place of Death (Check only one) examiner? Hospital Other:
4 Nursing Home 5 Residence 6 Other (Spe 2 No |요 1 🔀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred the stand overturned 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 ☐ Natural
2 ☑ Accident
3 ☐ Suicide
4 ☐ Homicide injury2:08 PM 5 Pending work? 1 ☐ Yes 2 🕱 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Retrieur Torro attelbryan Point at Bonds 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Street Roadway Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of Maryland	17 Depa Cen	irtment of F tificate of [	ieaith and Death	ı Mental Hy	rgiene 2	012	40297
ì	Physicia		1. Decedent's Name (First, Middle, Last)  Walter	Gillia	m			2. Date of D Month		2012 2012	3. Time of Death 3:59 P M
	Medic Examin		4a. Facility Name (if not institution, give stre	eet and number)		4b. City, Town, or		Dec.		nty of Death	13.33 1
,	Funeral		906 North Eden St 5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	Baltimo  If Under 1 Year  Months   Days	If Under 24 H	n. (Month, D	ay, Year)		lace (State or Foreign try)
	Director		Usual Residence of Decedent		Yrs.			05-04	-21	1.	VA
	// Aaryland 8a-f sho tified at	Director	10a. State 10b. County NA		Town or Loc Baltin					[	0d. Inside City Limits
	vith the h 23a or 2 st be no	eral Di	10e. Street and Number  906 North Eden St	reet.		10f. Zip Code 212	205		10g. Citizen o	of What Cour	try?
036	is filed within 72 hours after death with the Maryland tal Hygiene. cd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral		2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 XNo If Yes, Give Year or Dates,		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? ( n, Mexican, Pue	Specify Yes or No erto Rican, etc.)	-	ace - Americ lack, White, e	etc. African
Maryland 21215-0036	72 hour	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4 or 5+)	(Give k	ent's Usual Occup ind of work done of NOT use retired)		orking	16b. Kind of		
212	iled within I Hygiene. other tha	Be Co	6th Grade  17. Father's Name (First, Middle, Last)	NA		Cook	18 Mother's N	lame (First, Middle			Restaurant
ylan	ould be filed and Mental Hy marked oth martic event	To [	Edward	Gilliam			Martha			yne	
, Mar	is an		19a. Informant's Name/Relationship (Type, Josephine Gilliam-	11		g Address (Street a North Ede					
Baltimore,	Page 1 ar ient of He int: If iten ry or oth		20a. Method of Disposition  1 XX Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	mayal from Ctata Cer	meterv. crem	sition (Name of natory or other place norial Pa	erk 12	Date 2-15-12	20c. Location Randa	•	
Balti	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Service Licensee	mater		Name and Addres					A. and 21217
ï			23a. Part 1. Enter the disease, or complices shock, or heart failure. List only one of Immediate Cause (Final	cause on each line.	Do not enter	r the mode of dyin	g, such as cardi	ac or respiratory a		ridz y z	Approximate Interval Between Onset and Death
)	Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque	nce of):	Janac	ciclen	14		_	Onsol and Boam
		ner	Securitially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):	30	_				
10	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque		tery	Disco	we_		-	
90	ate be e physiciar the buris	ledical	C d.								
. Box 68/	law requires that the death certificate be nas been signed by the attending physici e 2 should be detached for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	c. If yes, outcome of pregnand 1  Live Birth 2  Fetal of 4  Pregnant at time of de 9  Unknown	death 3 🗌	Ectopic pregnand Other (specify)	у			Date of delive Month	ery Day Year
s, P.O.	ires that the signed by do be deta	by	Part II. Other significant conditions control  Arrial Falor		ting in the ur	nderlying cause giv	ren in Part I.				e cause of death? pably 4 🗡 Unknowп
Division of Vital Records,	law requires been e 2 shoul	Completed	Atrial Fibr Renal Fa	elune				24a. Was	DSV	o. Were autor prior to con death?	osy findings available mpletion of cause of
al Re	ian: The rtificate		25. Was case referred to medical			26. PI	ace of Death (Cl		ormed? 2 No	1 Yes	2 XNo
1 VIE	Physici this cerral direc	욘	examiner? 1 Yes 2 No  27. Manner of Death	spital:  1  Inpatient 2 E  28a. Date of injury 2	R/Outpatient	t 3 DOA Othe	4 L Nursing	Home 5 Res	idence 6 0		)
o uoi	tending leath. or: After the fune	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 No	200. Describe		ined	
DIVIS	tal or Attracts all Direct		4 Homicide determined	28e, Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office			Street and Nun wn, State)	nber or Rural	Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check 2 Medical Examiner	an: To the best of my knowled r: On the basis of examination a Practitioner: To the best of my	and/or investi	igation, in my opinio	n, death occurre	d at the time, date	and place, and	due to the cau	use(s) and manner stated.
	To the withing the complete co		29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month, I	
	5		30. Name and address of person who com	ipleted cause of death (Item 2	23a) (Type, Pr	rint) Anx	Lew	is, con	P		2010
	Stat	e	31. Date filed (Month, Day 2012	32. Registrar / Signar	ark	Jos, K	m/th	we, M	(D 3	130,	4
	Registra	ar	LIEU TO LOIL /O								

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AMEND ITEM#30perDVR, G934, 12/13/2012 WS
State of Maryland 7 Department of Health and Mental Hygiene 40298 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20 /ear 1431PM Wend aines drea Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Howard Columbia If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 341-46-9617 Director 1 🗆 M 2💢 F 60 Yrs. 06/07/1952 Illinois Usual Residence of Decedent er then "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4985 Columbia Rd. Apt. 101 21044 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status rmed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 hours after 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Black Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Options Elementary/Secondary (0-12) College (1-4 or 5+) Chicago Exchange Librarian permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Importent: If item 27 is marked other t. any Injury or other traumatic event, the ODCE. Yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Willis Geraldine Gold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) City Jill Driver (Sister) 5020 Walking Stick Rd. Apt.C Ellicott MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State On-Site Crematory 12 Baltimore, MD 4 Donation 5 Other (Specify) <sup>22</sup>Joseph H. Brown, Jr. 21. Signature of Funeral Service License 22Josephdrenof Family own, Jr. Funeral Home PA 2140 N. Fulton Ave. Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Acute Physician/ 25 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lue to (or as a consequence of): burlal-transit Exam Cause (Disease or injury that initiated events eumonia Due to (or as a consequence of): resulting in death) Last attending physician for use as the burla Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Day Year ours after death. eral Director: After this certificate has been signed by the af filled in by the funeral director, page 2 should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဍ 1 ☐ Inpatient 2 ☐ ☐ R/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 00027717 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) 2 Willie W. Bivings Jr. 5755 Cedar Lane Columbia, Md. 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2012 Registrar

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 10:50 P M Janice Lynn Gelwicks Medical <u>December</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate Hospice House If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth **Funeral** Months April 1 □ M 2 X F Days Min Day, Year) 948 Mary Land Director 217-50-1543 64 Usual Residence of Decedent 28a-f show 10b. County 10c, City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State with the Maryland Director 1 ☐ Yes 2X No MD Anne Arundel Glen Burnie 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 21060 United States 7846 Leymar Road Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Rep Miss Utilities 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Paul Otto Flatt Betty Sue Pearse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 7846 Leymar Road, Glen Burnie, Maryland 21060 James E. Gelwicks/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Departion 5 Other (Specify) cemetery, crematory or other place, 12/17/2012 Crownsville, Maryland 5 Other (Specify) Crownsville MD Vets 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 21. Signati Crain Highway SE, Glen Burnie, MD 21061 421 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? Jas this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) Hospice 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. 1 Natural 2 Accident (Month, Day, Year) 5 Pending work 1 ☐ Yes 2 ☐ No Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tho completed cause of death (Item 23a) (Type, Print) Name and address of person

DHMH 17 Rev 7/2009

State

Registrar

7621

3 2012

Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 40300 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Thomas B. Gunshinan 20T2 1438 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Olney Medstar Montgomery Medical Center Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Day, Year) 126-16-8175 Director 1 X M 2 □ F 85 01/22/1927 New York Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Funera U.S.A. 15411 Johnson Road 20905 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decession Armed Forces?

1 X Yes 2 No WWII

If Yes, Give

Year or Dates. Korea 1 Never Married 2 X Married 호 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Aerospace Engineer Aerospace permit. Page 1 and 2 should be filed Department of Health and Mental Hy. Important: If item 27 is marked othe any injury or other traumaticance. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas J. Gunshinan Marie Clay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Marie Tombros - Daughter 15411 Johnson Rd., Silver Spring, Maryland 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 12/13/2012 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Picensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MD 0730 11800 New Hampshire Ave., Silver Spring, MD 20904 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mphoma disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Rewal Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or injury Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. The second of the third the tring physician and the Funeral Director. After this certificate has been signed by the attending physician and mpletely filled in by the Inuneal director, page 2 should be detached for use as the burial-transit electroly that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death Day 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 death? 1 Yes 2 No Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ျှ 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifier

State Registrar Hamitt J Si

31. Date filed (Month, Day, Year)

NFC 1 3 2012

Joseph Garrett Reilly, M.D., 3418 Olandwood Court, #111, Olney, Maryland 20832

D 39190

MD

32. Registrar's Sgnatui

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Daluska 3:10 Decomber Medical -tohen 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memor KESWICK saltimore Baltineave 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days 1 X M 2 □ F 184 16 4660 91 Director 10/11/1921 Pennsylvania Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A 1 X Yes 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4140 Doris Avenue 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐
If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 🕅 Widowed 4 🗆 Divorced WW II Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse Electrical Engineer 4 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Michael John Galuska Anna Dykla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Galuska / Daughter 4140 Doris Avenue Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 12/08/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service u 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that defised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final End Dementia Physician/ Stag year disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 phys. as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death g Unknown 9 Unknown P.O. by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Whiknown Records, Completed 24a. Was an Were autopsy findings available prior to completion of cause of death? has je 2 2 No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes Natural 5 Pending 1 Accident 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif D71079 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40302 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:24 PM Rosalie Claire Griisser 20 ั 1 ั 2 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Morningside House of Friendship Hanover 9. Birthplace (State or Foreign Country) Maryland Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 💢 Months Hours (Month, Day, Year) 08/15/1915 97 Director 214 52 8081 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Anne Arundel Hanover 1 Tes 2X No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 895 Forest Lane 21076 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Specify. 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mehtal Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ James L. Drinks Mary McCormick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hanover, Maryland 21076 Rosemary Hall / Daughter 895 Forest Lane Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 12/07/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses Baltimore, Maryland 21225 4001 Ritchie Highway namerou complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure List Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (of as a consequence of) ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Division of Vital Records, P.O. Box 68760 695, To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No the be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \) Yes 2 24a. Was an has certificate Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be PJJ (180 Other: 4 Nursing Home 5 Residence 6 Nother 2 4 NO 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

31. Date filed (Month, Day, NFC 13

of person who complete

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32. Registrar

ause of death (Item 23a)

29c. License number

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29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tir Month 12 Day ()9 Physician/ 2012 6:00 AM Gabel JoAnn Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 23 A Cedar Drive Middle River Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birtholace (State or Foreign **Funeral** (Month, Day, Year) 05/19/1947 Days Min Director 1 🗆 M 2 🔀 F Pennsylvania 203-36-1268 65 Usual Residence of Deced 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 1 X Yes 2 No MD **Baltimore** Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23 A Cedar Drive 21220 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Merchandiser Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Joseph Gabel Jean O'Hara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Althea Court, Bel Air, MD 21015 Andrew Feher / Son 20b. Place of Disposition (Name of cernetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/11/2012 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall juite Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between 9nset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ etas Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) filled in by the funeral director, page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🏿 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar ec

ltimore

nd address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signa

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20 c Physician/ EMEN SENOL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Country Director 213-37-8837 1 🛛 M 2 □ F 85 Yrs. 10/22/1927 Usual Residence of Decedent RUSSIA 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No BALTIMORE MD PIKESVILLE 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral Itams 23a 7920 SCOTTS LEVEL ROAD 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò <u>\$</u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: "natural", Completed 3 Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Paga 1 and 2 should ba filad within 72 mant of Haalth and Mantel Hygiana. ent: If Item 27 Is marked other than ' College (1-4 or 5+) Elementary/Secondary (0-12) ELECTRICAL ENGINEER GOVERNMENT other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ NAFTOLIY GERTSENOV RAHEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRINA GERTSENOVA/DAUGHTER ROCKLAND HILLS DRIVE, #505, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Injury or 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Paga Departmant of Importent: If any Injury or 4 Donation 5 Other (Specify) BALTIMORE HEBREW 12/12/2012 REISTERSTOWN, MD 21. Signature Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysiciana e disease or condition resulting in death) Medical as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami ettanding physician and I for usa es tha burlal-trensit the Hospital or Attending Physician: The law requiras that the daath cartificata be axecuted Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ No eta has baen signed by tha e paga 2 should be datachad q 🗌 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use convibute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ,24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No perform After this certificeta 2 🗆 No 1 🗌 Yes Director: After this certific d in by the funarel director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital nos Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 **1** No 1 1 Yes |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man r of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No daeth. 2 Accident 3 Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 24 hours after of Funeral Direct 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completaly Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title

Registrar

30. Name and address of person who completed

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cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 40305 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ĩó Rosa Marie Hancock 2012 1:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Year) 08/19/1956 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. Director 1 M 2 F 218-66-6211 56 Maryland Usual Residence of Dece ıral", or items 23a or 28a-f show I Examiner must be notified at 10b. Count 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4521 East West Highway, Apt. 1212 20814 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify: 3 Widowed 4 Divorced Completed Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic ever မ Charles Owens Annie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Owens / Brother 1303 Baker Place East, Apt. 24, Frederick, MD 21702 Baltimore, nt of Heal t: If item 2 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State Department c Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/12/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marsall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sensis Medical Due to (or as a consequence of): Examiner Stage IV Decubiti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Vear g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate 2 🗷 No 1 Yes 2 No Yes eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) +105 pice 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred injury Matural Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Curtifying Nurse Practitioners To the basis of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated. (Check

Division of Vital Records, within 24 hours

> Geofrey Coleman, M.D. 1355 Piccard Drive, Rockville, MD 20850 31. Date filed (Month, by, Year) State Registrar

ess of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

30. Name and add

29c. License number

D37142

29d. Date signed (Month, Day, Year)

12-10-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Leonarde Hemby Dec. Devon 20**T**2 10:12 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3053 Brighton Street Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 11-26-41 9. Birthplace (State or Foreign Days Country) 245-64-9672 Director 1**X**XM 2 □ F 71 NC or than "naturel", or items 23a or 28e-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Directo MD NA Baltimore 1 No Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3053 Brighton Street 21216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. African þ 1 KNever Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: American Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Factory Worker Steel Company 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mental H permit. Page 1 and 2 should be Department of Health end Ment Importent: If item 27 Is market eny Injury or other traumetic e once. Robert Hemby Laura Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Lea-Street-Cousin 4014 Duvall Avenue Baltimore. Maryland 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State 12-16-12 Midgettefield Cem. Greenville, NC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on ear Interfal Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as a consequence of) ettending physician end I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Day 9 Unknown Hem by Part II. Other signi nd ons contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate hes been si irector, page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed<sup>2</sup> death? 2 No Yes 2 1 🗌 Yes after death.

Director: After this certification by the funeral director, Hospital or Attending Physicien: æ 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) 2 1 No Other: 4 Nursing Home |요 1 | Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA esidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manna of Death 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be within 24 hours after dea To the Funerel Director completely filled in by the 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) dete rmined Medical 29a. Certifier 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date sig ed (Month Day, Year)

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Paula Holmes November 27, 2012 11:57 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 751 W. Saratoga Street #220 Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 137-28-1261 1 □ M 2 □ XF Months Days Hours Min. 75 11/30/1936 NJUsual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt 220 21201 751 W Saratoga St USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Toria Long Granddaughter 8885 Parkwood Manor Belleville 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie MD 12/12/12 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) HROWLC Dank Due to (or as a consequence of): 20 yes ZUNDE Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day Year 5 Other (specify) 9 Unknown 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Husund WOLFGOSUMONN 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examiner Physician: The law requires that the death certificate be executed

Physician

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "motical Examination ust be notified at

72 hours after

filed within I

12 should be filed with and Mental Hygier 7 is marked other tt

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once.

Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital Records,

/Medical

10a. State

MD

Director

Funeral

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physician and sthe burial-trans aftending p for use as t the ed by 1 detach funeral director After this after death.

ģ Completed Be

Physician/Medical

Medical

Certification: To

State Registrar

DHMH 17 Rev 1/2001

Hospital or Attending

filled in by

within 24 hours at To the Funeral D completely filled i

ACLCHARD

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 🗌 Homicide

(Check only

29b. Signature and title of certifier

5 ☐ Pending

investigation

determined

6 Could not be

NW

29c. License number 0.13619

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

11-30-12

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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28a. Date of Injury

(Month, Day, Year)

31. Date filed (Month, Day, Year)

3 2012

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ano Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington med Social Security Number If Under 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Min. Director 214-46-2179 1 M 2 X F 68 09/01/1944 Kansas ed other then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours aftar daeth with the Marylend 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1207 Gillia Court 21122 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 K No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry f Health and Mantal Hygiane. Item 27 is merked other then other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Paga 1 end 2 should ba fili. Department of Health and Mantal | Importent: If Item 27 is merked c eny injury or other traumatic eve ည Fred Raymond Davis Virginia Loraine Hustead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl Philhower / Son 1207 Gillia Court, Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Anatany Gifts Registry 12/13/2012 Hanover, Maryland 21. Signature of Fune al Service License 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 0 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or a consequence of ate has been signed by the attanding physicien and paga 2 should be datachad for use as tha burlet-transif The lew raquiras that tha death certificete ba axecuted resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day 9 Unknown 9 Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aftar this cartificate 1 Yes 2 No or Attending Physician: 24 hours eftar death.
Funeral Director: Aftar this cartifice ataly fillad in by tha funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospitai Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сопрівтаї 2 Medical Exarriner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the l only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4a, perpHYS, G934, 12/13/2012, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 95 lliam Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good amaritan Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 227-54-2174 Director 1 M 2 □ F Usual Residence of Decedent 19ortent: If Item 27 is marked other then "natural", or items 23a or 28e-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents if Item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10d. Inside City Limits Director MI imore 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Kuaa 21239 USA entwood 12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☑ Married Black, White, etc. Š Baltimore, Maryland 21215-0036 Specify: Blac 1 ☐ Yes 2 ☑ No Specify: 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) artmen? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ UnKnown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Vas MD21239 090 imore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-2012 1 timore 21. Signature of Funeral Service Licensee Address of Facility aughn Gracine Funeral Services 05 Koga York Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition ard iac thinks Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, cooling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director: page 2 should be detected. Hu nertension Due to of as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Day Pregnant at time of death Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed?

Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? မ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) DC062689 te ini) November 30, 2012 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8ha 31. Date filed (Month, Day, Year) State 32. Redistrar's 2012 Registrar

			Please Type or Famend item I State of	Print in Black In per doc 9934	n <b>delible Ink. Ensur</b> 1 12–18–12 <b>vt</b> artment of Health an	re All Copies A	re Legible.	
			1 - State Registrar		rtificate of Death		No.2012	40310
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Mamie	Jackson .	TACKSON	2. Date of Death Month	Pay 2012	3. Time of Death
don	Medic Examin		4a. Facility Name (if not institution, give street and number	ar)	4b. City, Town, or Location of D	leath Nay o	4c. County of Death	11:15 PM
20	}			tome	ainton		P6	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 7. Usual Residence of Decedent	Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24  Months Days Hours M	Hrs. 8. Date of Birth Alin. (Month, Day Yea	1935 9. Birthol	ace (State or Foreign
	Maryland 28a-f shov otified at	Director	10a. State 10b. County P6	10c. City, Town or Lo			10	od. Inside City Limits 1 X Yes 2 □ No
	n with the is 23a or nust be n	Funeral D	10e. Street and Number 911 Stewart Lane	2	10f. Zip Code 20735	10g.	Citizen of What Count  USA	ry?
9800	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  1 □ Yes, Give Year or Date	No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pi  1 ☐ Yes 2   No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - America Black, White, e	
21215-0036	led within 72 hou Hygiene. other than "nati ent, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary(Seconday (0-12)  College (1-4	(Give I	dent's Usual Occupation kind of work done during most of O NOT use retired) - UDLY VISOR	working 16b	Eximate A Eximes Head (	ustry
Maryland	should be filed and Mental Hy, is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) Daniel E. Medle	М	18. Mother's	Name (First, Middle, Maide	en Surname) NASON	
	and 2 should Health and Mi tem 27 is mar ther traumati		19a. Informant's Name/Relationship (Type, Print) Antoinette Jackson-G	Moght 196. Mailir Ins 1534	ng Address (Street and Number of + Monroe St	Rural Route Number City	or Town, State, Zip Co	20010
Baltimore,	O		20a. Method of Disposition  1	20b. Place of Dispo cemetery, cren	esition (Name of matory or other place)  Cenuctry 6	Date 20c	Location City or Tov	vn, State
Ball	permit. Page Department Important: I any injury o	Į,	21. Signature Funeral Service Log see	<b>V</b> 22 4	2. Name and Address of Facility F	REEMANS F	FUNERAL HillsimD	services
	nysician/ Medical Examiner	8	23a. Part 1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each Immediate Pause (Final disease or condition resulting in death)  a	used the death. Do not enter line. LAS Lot as a consequence of):	er the mode of dying, such as care			Approximate Interval Between Onset and Death
\$ 00	ath certificate be executed attending physician and for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.	as a consequence of):				
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death certificate be 124 hours after death after this certificate has been signed by the attending physici sted filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medica		th 2 Fetal death 3 nt at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliver	ry Day Year
s, P.O.	requires that the der been signed by the should be detached	þ	Part II. Other significant conditions contributing to dea	th but not resulting in the u	inderlying cause given in Part I.		co use contribute to the	
ecord	s law requi has been ge 2 should	Completed				24a. Was an autopsy performed	24b. Were autopoprior to com	sy findings available npletion of cause of
E E	sician: The law of certificate has to irector, page 2 s	Be Co	25. Was case referred to medical		26. Place of Death (	1 🗆 Yes 2 🖶		2.DNo
Vit	hysici his cer Il direc	욘		patient 2 ER/Outpatien		ng Home 5 🗆 Residence	6 ☐ Other (Specify)	
n of	ding P th. After t funera	cate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	injury 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: "In thin 24 hours after death as the Funeral Director. After this certifica completed filled in by the funeral director, it	Certificate:	3 Suicide 6 Could not be	Injury - At home, farm, stre , etc. (Specify)			and Number or Rural F ate)	Route Number,
)	the Hospit thin 24 hour the Funera mpleted fille	Medical	29a. Certifier 1 Certifying Physician: To the bes (Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practioner: To	of examination and/or invest	tigation, in my opinion, death occur	red at the time, date and pla	ace, and due to the caus	se(s) and manner stated.
	To the within 2 To the Complete		29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, D. 96-01-2	ay, Year)
_	Ф		30. Name and address of person who completed cause MicHAEL Side MAS, M-A	of death (Item 23a) (Type, P	29c. License number  NYS365  Print)  Print)  Print NS B	101, ft an	, higher r	1120184
	Stat	e	31. Date filed (1013, 20 (21) Person 22. Reg	strar's signature		, = -		

			State of Maryland / Departme	ent of Health and	d Mental Hyg	iene	
				ate of Death	Re	eg. No.20   2	40311
	Physicia	ın/	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Medic	cal	James Henry Johnson		Decembe	r <sup>1</sup> 11, 2012	2:45 pm
)	Examin	er	4a. Facility Name (if not institution, give street and number)  11417 N. Star Drive	ity, Town, or Location of Dea		4c. County of Death	
	Funeral			Ft. Washi			e George's
	Director		579-64-4379 1X M 2 □ F 64 Yrs. Month	hs Days Hours Mi	n. (Month, Day,	Year) Cou	ntry)
	d t ow		Usual Residence of Decedent		July 03,	<u> </u>	hington, DC
	ırylanı I-f sh ied a	턍	Maryland Prince George's	Ft. Washi	no ton		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 288	Director		Zip Code		0g. Citizen of What Cou	
	with th	eral	11417 N. Star Drive	20744			S.A.
	is filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	cedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ameri	ican Indian,
9	fter d ", or i amin	by	1 Never Married 2 M Married 1 Never Married 2 No 1968-	pecify Cuban, Mexican, Pue s 2 🕱 No Specify:	erto Rican, etc.)	Black, White,	, etc.
ğ	ours a Itural	sted	Year or Dates. 1970				Black
21215-0036	72 ho in "na Medio	Completed	itte DO NOT	work done during most of w	rorking	16b. Kind of Business/Ir	ndustry
212	within giene. er tha the l		Elementary/Secondary (U-12)   College (1-4 or 5+)	Truck Driver		Private Co	ontractor
	filed all Hyg	Be (	17. Father's Name (First, Middle, Last)	18. Mother's N	lame (First, Middle, M	aiden Surname)	
<u>X</u>	d Mental d marked o	욘	James Henry Johnson		Bess	ie Johnson	
Maryland	She is			ess (Street and Number or F			
	e u		Sandra Johnson - Spouse 11417 N.  20a. Method of Disposition 20b. Place of Disposition (A	Star Drive,			
no D	Page 1 nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	or other place)		20c. Location - City or T	
Baltimore,	permit. Pa Departme Importan any injury	-		Cemetery 12/ and Address of Facility Hu			
ñ	permit. Page 1 ar Department of He Important: If iter any injury or oth once.		Bunna 6 Kenny 0730 11800	New Hampshir	re AveSi	ac Funerac Lver Sprin	9.MD 20904
			3a, Part 1. Enter the disease, or complications that caused the death. Do not enter the my shock, or heart failure. List only one cause on each line.				Approximate
× I	hyuician/		mmediate Cause (Final disease or condition Hepatocellular Carc	inoma - Metaz	static	- 5	Interval Between Onset and Death
٦	Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		er	Sequentially list conditions, b.				
	ed nsit	Examiner	dray, leading to immediate cause. Enter Underlying Cause (Disease or injury)				
	executed an and irial-transi	Еха	that initiated events c. Due to (or as a consequence of):				
20	ate be executed shysician and the burial-transit	dical	d.				
0/20	To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 burns after death certificate that within 24 burns after death. After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burns later than 15 burns and 15 burns and 15 burns and 15 burns and 15 burns are the burns at 15 burn	Med	IF FEMALE:				
ŏ ×	h cert tendir or use	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	ic pregnancy		23d. Date of deliv	/ery
20X	the att	/sici	in the past 12 months?  1   Yes 2   No 4   Pregnant at time of death 5   Other 9   Unknown		and the second	Month	Day Year
7. Ö.	at the d by t detacl	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlyin	ng cause given in Part I.	23e Did tob	acco use contribute to t	he cause of death?
ν, T	ires th signe d be d	d by	Chronic Hepatitis C			s 2 <b>X</b> No 3 □ Pro	
9	been	lete	Status Post Liver Transplant - 03/29/20	0.10	24a. Was an		ppsy findings available
Vital Records,	ne law e has age 2	Completed	Status Post Level Transpeare - 03/29/20	112	autopsy perform	prior to co	ompletion of cause of
r E	an: Th tificat tor, pa		25. Was case referred to medical	26. Place of Death (Ch		X No 1 Yes	2 L No
N I	lysicia is cer direc	70 B	examiner? 1  Yes 2 X No  Hospital: 1  Inpatient 2  ER/Outpatient 3	Other:	***	nce 6 Other (Specific	v)
5	ng Ph fter th ineral		27. Manner of Death  1 📈 Natural 5 🗆 Pending  28a. Date of injury (Month, Day, Year)  injury	28c. Injury at work?	28d. Describe how		·/
0	tendii leath. or: At the fu	ifica	2 ☐ Accident Investigation M 3 ☐ Suicide 6 ☐ Could not be	1 ☐ Yes 2 ☐ No			
DIVISION OF	or At after d Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office	28f. Location (Stree City or Town,	eet and Number or Rura State)	l Route Number,
2	spital lours leral (		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place	and due to the cause	ce/e) and manner as stat	ted
	n 24 h	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation, only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death o	in my opinion, death occurred	d at the time, date and	place, and due to the ca	ause(s) and manner stated.
	To the To the comp			9c. License number		d. Date signed (Month,	
			peguden Lam M	MD31154		December	12, 2012
- 1			30. Name and/address of berson who completed cause of death (Item 23a) (Type, Print)				
١			Jacqueline Laurin, M.D., 3800 Reservoir	Koad, NW, Was	shington,	VC 20007	
	Stat Registra	e ir	31. Date filed (Month, Day Year)  DEC 1 3 2012  32. Registrar's Signature  3. Apart				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Sadanala December Joseph 8:55 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sligo Nursing Home Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 215-66-9134 1 X M 2 🗆 F 98 April 18, 1914 India Usual Residence of Decedent 28a-f show 10a, State 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Beltsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4009 Stoconga Drive 20705 U.S.A. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No
If Yes, Give 1 Never Married 2 Married Black White etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Ø Widowed 4 ☐ Divorced Specify: Year or Dates Asian Indian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) t. Page 1 and 2 should be filed with thrent of Health and Mental Hygier rtant: If item 27 is marked other thury or other traumatic event, the Pharmacist Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Samuel Sadanala Mahaniyama Injety 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Yesudian/Son-in-Law 4009 Stoconga Drive. Beltsville. Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or ot 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 12/11/2012 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHines-Rinaldi Funeral Home. Inc. MOISCH Kathun 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
6 Months Immediate Cause (Final Physician, Dementia - Advanced disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner quentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease of it that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month signed by the at d be detached for Day Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atherosclerotic Cardiovascular Disease tor: After this certificate has been si the funeral director, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 💢 No Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Noto D28656 December 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D., FACP, CMD, 15245 Shady Grove Road, #130, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 DEC 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Montal Hydiones.

			For State Registrar	State of Maryla	and / Dep Ce	eartment of l ertificate of l	Health and I <i>Death</i>	Mental Hy	/giene2 0	12 40313
	Physic Med Exam	ical	1. Decedent's, Name (First, Middle, L 4a. Facility Name (if not institution, gi	Jachimow	ICZ			2. Date of D		20a12 3. Time of Death
	LAdiii	iller	15 Mapledale A				r Location of Death n Burnie		4c. County	of Death Arundel
	Funera Directo			37	s. last birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	rth	Birthplace (State or Foreign
	3	١.	Usual Residence of Decedent		Yrs.		, and	10/23		Country) Maryland
	aryland a-f sh	Director	10a. State 10b. County  Maryland Anne		City, Town or Lo					10d. Inside City Limits
	tha M	i i	10e. Street and Number	Arundel	Glen B	1rnie		- T		1 ☐ Yes 2 🌠 No
	th with	Funeral	15 Mapledale A	Avenue		210	61	j	10g. Citizen of W	
920	be filed within 72 hours after death with tha Maryland antal Hyglane. Ked other than "natural", or Items 23a or 28a-f show c avent, the Madeal Evaniner must be notified at	2	Marital Status     Never Married 2 ☒ Married     Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Å Yes 2 No If Yes, Give		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- American Indian, k, White, etc.
5-0	2 hour "natur	plete	15. Decedent's i (Specify only highest g	ducation	16a. Dece	dent's Usual Occupa	ation		Specily:	White
121	vithin 72 hour lane. Ir than "natu	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	kind of work done d O NOT use retired)	luring most of worki	ng	16b. Kind of Bu	siness/Industry
D S	e flied wil Ital Hygla ed othar avent, th	Be	17. Father's Name (First, Middle, Last)	2 years	Ger	eral Ager I		T		Railroad
Maryland 21215-0036	should be fli and Mantal Is marked of	မ		Stanley Jachi	mowicz	i	18. Mother's Name	e (First, Middle, Sphine	<i>Maiden Sumame)</i> Maciejew	ski
Ma	ge 1 and 2 should bo it of Health and Mar if item 27 is marks or other traumatic		19a. Informant's Name/Relationship (I Harriet Jachimow		19b. Mailir	g Address (Street a	nd Number or Rura			
ore,	of Health of Health of Item 27		20a. Method of Disposition	206		pledale A				Maryland 21061
Baltimore,	t. Page tment tant: I		1 X Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	J Removal from State MD	cemetery, cren	atory or other place	em. 12/07	/2012		City or Town, State
Bal	parmit. Page 1 g Department of F Important: If its any Injury or ot		21. Signature of Juneral Service Open	dridge.	22	Name and Address	s of Facility Gon ie Highwa	ce Fune	ral Serv	ice, P.A. laryland 21225
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	plications that caused the dear ne cause of each line.  a. Due to (or as a conseq	th. Do not ente	the mode of dying	, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
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9760	iffcate be executed 1g physician and as the buriai-transit	Medical		d						
Ó	± 50 m		FEMALE: 3b. Was decedent pregnant	23c. If yes, outcome of pregna	ncy					
P.O. Box	hat the death cert ad by the attendin detached for use	Completed by Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1  Live Birth 2  Feta 4  Pregnant at time of c 9  Unknown	death 5	Ectopic pregnancy Other (specify)			23d. Date o Month	•
	requires tha baen signad should be d	od by	art II. Other significant conditions co	ntributing to death but not res	ulting in the un	derlying cause giver	n in Part I.	_		ite to the cause of death?
Records,	has ba	nple.						24a. Was an	24b. Wer	e autopsy findings available
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Div	ours after d eral Direct filled in by	<u> </u>		building, etc. (Specify)				City or lown,	State)	Rural Route Number,
Had Hose	within 2 bours after dear	D	only one) 3 L Certifying Nurse	cian: To the best of my knowle er: On the basis of examination Practitioner: To the best of m	edge, death occ and/or investiga y knowledge, de	curred at the time, d ation, in my opinion, eath occurred at the t	ate and place, and death occurred at the time, date and place,	due to the cause time, date and and due to the	e(s) and manner a place, and due to t	s stated. the cause(s) and manner stated.
م ا	8 48		Mark	M	MA	29c. License nu	872	29	d. Date signed (Me	onth, Day, Year)
_	13,		Name and address of person who co	mpleted cause of death (Item 2		Kim Bi	W/ 1	los R	m n'in	21061
	State Registrar		Date filed (Month, Day, Year)  DEC 1 3 2012	32. Registrar's Signatu			-/1 ()-/	ch v	IN II IP	
DUBAL	17 Day 00 00	14								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40314 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1814 ENNETH Medical 12 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CENTER BALTIMORE, MARTLANO UNIVERSITE OF MARYLAND MEDICAL N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 220 74 2329 Months Hours Director 1 **X** M 2 □ F 54 07/21/1958 Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits the Medical Examiner must be notified 28a-f Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 23a Funeral 2726 Alderwood Avenue 21227 U.S.A. filed within 72 hours after death val Hyglene. Jother than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give Black, White, etc. <u>Ş</u> 1 Never Married 2 Namied Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Driver B.W.I. Be 17. Father's Name (First, Middle, Last) and Mental ⊬ is marked of 18. Mother's Name (First, Middle, Maiden Surname) Kenneth R. Jones be Mildred Myers permit. Page 1 end 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Jones / Wife 2726 Alderwood Avenue Baltimore, Maryland 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 12/13/2012 Baltimore, Maryland 21. Signature of Pineral Service D 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ENCOPHALOPATHY disease or condition DAYS Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ASHEROSCIERESTE 15 4.25 Examine Due to for as a sonsequence of: 15 YRS or Attending Physician: The law requires thet the deeth certificete be executed CARDIONYSPHING ISCHEPHIC attending physiclan and I for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death ed by the a Yes 2 ☐ No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe e Division of Vital Records, Completed been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy certificate 1 🗌 Yes 2 No 1 🗌 Yes or: After this certific the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fu 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 3 🔲 29b. Signature and title of certifier 29c. License numbe

State Registrar a

2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R.E. HODD, 1610 (INIUES IT 4 OF MARGELING MEDICAL CENTER;

32. Registrar's Signature

12-11-12

22 S GREENE ST BACTIMONE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Irving Keys 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Hebrew Home of Greater Washington Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Days Months Hours 376-09-7729 1 X M 2 □ F 11/18/1916 96

3. Time of Death Physician/ 8:15 pm Medical Examiner Montgomery Birthplace (State or Foreign Country) Funeral Director New York 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits deeth with the Merylend Directo rel", or items 23e or 28e-f a Examiner must be notified Maryland Montgomery Rockville 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6105 Montrose Road 20852 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No δ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours efter 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Merchandise Manager Clothing 12 other å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Abraham Schlissel Rebecca Eistein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8901 Cherbourg Drive, Potomac. Maryland 20854 Marshall Keys - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Judean Memorial Grdns: 12/12/2012 Olney, Maryland 4 Donation 5 Other (Specify) 21. Signatore of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each kee. Interval Between Onset and Death Immediate Cause (Final Advanced Dementia Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). is certificate has been signed by the ettending physicien and director, page 2 should be detached for use as the burlei-transit Exam Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🗷 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours efter deeth.

To the Funeral Director: After this of completely filled in by the funeral directors. After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 ► Natural 2 □ Accident injury 5 Pending 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier

1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mina D006487 12-11-12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fazli 6121

20852 Rockville Montrase MD

State Registrar

31. Date filed (Month, Day, Year) NFC 1 3 2012

40316 State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 6:35 am Samuel Kaizen 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11519 Michele Court Silver Spring Montgomery 5. Social Security Number Birthplace (State or Foreign Country) Funera 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 578-44-2447 Director 1 🛛 M 2 □ F 77 April 09.1935 New Jersey "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Silver Spring Maryland Montgomery 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11519 Michele Court 20904 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Amped Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Page 1 end 2 should be filed within 72 hours after nent of Health end Mental Hygiene. ant: If item 27 is marked other then "natural", or Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Korea Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Owner Accounting Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Kaizen Rose Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11519 Michele Court, Silver Spring, Maryland 20904 Rita Kaizen - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
eny injury or o 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Grdns [12/11/2012 | Falls Church, Virginia 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses AnneMaur Hutz 11800 New Hampshire Ave., Silver Spring, MD 20904 7W1232 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 5 Weeks Physician/ disease or condition resulting in death) Cellulitis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Yes 2 No 1 L Yes 2 L 9 Unknown After this certificate has been signed by the funeral director, page 2 should be detached g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Urinary Tract Infection 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Parkinson's Disease 24a. Was an Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerry Schapp, M.D., 11161 New Hampshire Avenue, #201, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 40317 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Murphy Lewis A M 0850 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samovitan Hospita Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 90 Director 216-16-2524 1 □ M 2XXF Maryland July 15, 1922 ir then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore Maryland 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8719 Avondale Road 21234 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ð 1 ☐ Yes 2 🕅 No If Yes, Give 1 Yes 2XXNo Specify: Specify: White Completed 3√Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within 72 Pof Health and Mantal Hygiene. item 27 Is marked other then "nother traumatic event, the Wool (Specify only highest grade completed) Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Veterans Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Herbert Ehrhart Marie Theresa Cremens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2807 Harford Road, Fallston, MD 21047 Timothy Murphy - Son If item 2 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Paga 1 Evans Funeral Chapel and Cramation Services -BelAir Dec. 13, 2012 1 Burial 2 X Cremation 3 Removal from State permit. Paga Dapartment of Importent: If eny Injury or once. 4 Donation 5 Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services — Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Severe Sensis disease or condition Medical resulting in death) Due to (or as a consequence f) Examiner nours 211115 Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a confliction of or Attending Physician: The law requires that the death certificate be axacuted Due to (or as a consequence of): resulting in death) Last tha attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy within 24 hours after death.

To the Funeral Director: After this certificate has baen signed by the atter completely filled in by the funeral director, pege 2 should be detached for a in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 ☐ Other (specify) Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Kidney Disease - St. 10; Coronary antery 1 Yes 2 No 3 Probably 4 Unknown Disease atrial Fibrillation; alzhemer's 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မူ Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier Res 000 30. Name and audress of person who completed cause of death (Item 23a) (Type, Print) 1,9 Khimberley Santiago M.D 5001 Loch Baven Bird Baltimore 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State Registrar

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arrell Logan		1- For State Registrar	tate of Marylar		artment o rtificate o		d Mental		Reg. No. 20	12 4031
Physici Medical Exami		1. Decedent's Name (First, Midd Tarrell	dle,Last)	Loga	n	<del></del>		2. Date of De		3. Time of Death 1755 hrs
		4a. Facility Name (if not instituti	on, give street end num			4b. City, Town, or	Location of De		er 10, 2012 4c. County of	
/		University Hospital	1-			Baltimore				NA
Funeral Director		5. Social Security Number	6. Sex 7	Age (In yrs. la	ast birthday) Yrs	If Under 1 Yea  Months Days				Birthplace (State or Foreign MD)
Any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Locat	ion				10d. Inside City Limits
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ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	0			10f. Zip Code	7		10g. Citizen of Wha	•
vith the s 23a o		1621 Vincent	12. Was Dece	lent Ever in II	S 142 10/a	2121		6 " V	US	
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	by Funeral	1 X Never Married 2 No. 1 No.	Armed Ford    Armed Ford   1	ces? 2 No		is Decedent of His es, specify Cuban Yes 2 No	, Mexican, Puer		White,	American Indian, Black, etc. African American
hours natur	ted t	15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a, Deceden during m	it's Usual Occupat ost of working life.	ion (Give kind o	of work done etired)	16b. Kind of Busi	ness/Industry
1215-0036 Id be filed within 72 houdenla Hygiene. narked other than "nat	Completed	11 th Grade  17. Father's Name (First, Middle	NA	or 5+)		aborer			various	jobs
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umartic event, the <u>Medical</u>	Be	Sylvester  19a. Informant's Name/Relation.	Peter	kin			Renee		Maiden Surname) Tyler	
	P <sub>C</sub>	Renee Tyler-Mc			1621	Vincent	Court		mber, City or Town, ce, Maryla	and 21217
Baltimore, MD 2 permit. Pages I and 2 shou Oepartment of Health and Important: If item 27 is r injury or other traumatic		20a. Method of Disposition  1 XXBurial 2 Crematio  4 Donation 5 Other S		State 20b. F	crematory or oth	ition (Name of center place) Cemetery	·	Date -20-12	20c. Location - C Lansdov	vne, MD
Baltimo permit. Page Department o Important:		21. Signature of Funeral Service	Licensee			lame and Address		Wylie Fu	ineral Hom imore. Ma	ne P.A. aryland 21217
Physician /Medical	1	23a. Part I. Enter the disease, of failure. List only one cause	complications that cause on each line.	sed the death.	Do not enter th	ne mode of dying,	such as cardiad	or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Wo							Death
		Sequentially list conditions,	Due to (or as a co	insequence or	7.					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a co	nsequence of	·):					
60, de be executed by sician and e burial - transit	EXa	events resulting in death) Last	Due to (or as a co	nsequence of	):					
<b>50,</b> te be executed sysician and build build build.	ledical	UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	-21	IF FEMALE: 23b. Was decedent pregnant in ti past 12 months?	4 Pregnan	n t at time of dea	2 Fet	tal death 3 [	Ectopic preg	nancy	23d. Date of de Month	Day Year
D. B.	Ph	Part II. Other significant condit	9 Unknow		esulting in the u	nderlying cause gi	ven in Part I	23e Did	tobacco use contribu	ite to the cause of death?
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of Vital Records, ig Physician: The law requir. The the requir. The the requirement that the remaining the result of the result	Completed							24a. Was		re autopsy findings available or to completion of cause of
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Vital Rec ysician: The I his certificate I director, page	a	25. Was case referred to medica examiner?	I be a site of the second				of Death (Chec			
ing Phys After this funeral di	음	1 Yes 2 No 27. Manner of Death	Hospital: 1 ✓ Inpa		ER/Outpatient 28b. Time of In		at Work?		how injury occurred	Other:
ion (trending death.	ation	1 Natural 5 Pend 2 Accident Inve	ding Dec 10, 20	Y Year)	1136 hrs	`	es 2 🗸 No	Subject sho		
Division pital or Attendio ours after death. teral Director: A	Certification:	3 Suicide 6 Coul 4 Homicide dete	d not be 28e. Place o	f Injury - At ho ocal Stree		t, factory, office bu	uilding, etc.	or Town,		or Rural Route Number, City altimore, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Plone) 2 Medical Exa	hysician: To the best of miner: On the basis of e	xamination an	e, death occum nd/or investigati	red at the time, dat on, in my opinion,	e and place, ar death occurred	nd due to the cau at the time, date	se(s) and manner as	s stated. to the cause(s)
F 3 F 8	₹	29b. Signature and title of certifie	and manner state	<del>г</del> и.		29c. License	number		29d. Date signed	(Month, Day, Year)
		leth/s	Sull M	<b>→</b>		O.C.N	1.E.		December 11	1, 2012
	1	30. Name and address of person Melissa Brassell, MD	who completed cause of Assistant Medic			. Baltimore St	reet, Baltim	ore, MD 212	23	
Sta Regista	_	31. Date filed (Month, Day, Year)	Augus A	trar's Signatur	· All					
		Date filed (Month, Day, Year) 32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 11,2012 Month December Physician/ 7:00 a M JoAnn Leleck Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery 16016 Faunlilly Court If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days (Month, Day, Year) Country 102-42-4516 Director 1 🗆 M 2 🗴 F June 14,1950 New York 62 filad within 72 hours aftar daath with the Maryland el Hygiana. d other than "natural", or Items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits od other than "natural", or Items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Rockville 1 ☐ Yes 2 🕅 No Montgomery Maruland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 U.S.A. 16016 Fawnlilly Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No 1 Never Married 2 X Married Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Education 5+ Chief Academic Officer Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Paga 1 and 2 should ba filad Department of Health and Mantel Hy Important: If Itam 27 is marked oth any liury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) မ Marie Brennan Joseph Assante 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16016 Fawnlilly Court, Rockville, Maryland 20853 Paul Leleck - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 12/14/2012 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Ligensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chiline. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Colon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be axacuted within 24 hours after death.

To the Funeral Director: After this certificate hes bean signed by the attending physician and completely filled in by the funeral director, pega 2 should be detached for use es the hurlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XI No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 🗌 Other (Specify) 1 🗌 Yes 2 💢 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) December 12, 2012 DC 19655 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

70

3800 Reservoir Road, NW, Washington, DC 20007

M.D..

Marshall.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40320 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 1 Physician/ James M. Lyday 11:55ам 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arden Courts Silver Spring Montgomery 6. Sex 1 **X** M 2  $\square$  F 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 28, 1930 9. Birthplace (State or Foreign **Funeral** Months Days Hours Oklahoma **Director** 444-26-1258 82 June Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 🗶 Yes 2 🗌 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 640 Street, SE 20003 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify. White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "I College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Federal Government Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ f item 27 is marked r other traumatic e Jack Lyday Zella Roach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a DC 20003 Noreen Lyday - Spouse 640 A Street, SE. washington. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 12/17/2012 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Rapidly Progressive Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pacemaker - 6 years old Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Due to (or as a consequence of) Physician/Medical Diabetes Mellitus Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperlipidemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) 1 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20274 December 11. 2012

DHMH 17 Rev 7/2009

State Registrar Bethesda, Maryland 20817

7710 Bradley Blvd.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Kirti Vohra.

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otate of Maryland		tificate of L		vicitairiy	Reg. No.	012	40321
Г	Physicia	an/	1. Decedent's Name (First, Middle, La	st) Ida Claire L	ovino			2. Date of De	ber 12	2 <sup>Year</sup> 12	3. Time of Death
24	Medic Examir		4a. Facility Name (if not institution, give	e street and number)	evane	4b. City, Town, or	Location of Death		4c. Cou	nty of Death	
ممسية			Laurel Regio	nal Hospital	at histholess	If Under 1 Year	. aurel	O Data of Div			George's
	Funeral Director			Sex 7. Age (In yrs. las		Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year) 1/1923	Cour	nplace (State or Foreign ntry) NSYLVANIA
	nd how at	ž	Usual Residence of Decedent  10a. State  10b. County	10c. City,	Town or Loc	ation		11/04	1/1723		10d. Inside City Limits
	Marylar 18a-f s ntified	rectc	Maryland How	vard			Fulton				1 🗆 Yes 2 💢 No
	th the ? 3a or 2 t be no	Funeral Director	10e. Street and Number		***	10f. Zip Code	00750		10g. Citizen		
	eath wi	une	11. Marital Status	anberry Lane 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi	20759 ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-	14. F	U.S.	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show my njury or other traumatic event, the Medical Examiner must be notified at ance.	Completed by F	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Yes, specify Cuba		Rican, etc.)	Spec	Black, White,	white
15-(	72 hoin "nat Medica	mple	15. Decedent's E (Specify only highest gi	rade completed)	(Give k	ent's Usual Occup kind of work done of NOT use retired)	ation during most of work	king	16b. Kind o	f Business/In	ndustry
	within giene. ner tha t, the I	S	Elementary/Secondary (0-12)	College (1-4 or 5+)		Homema	ıker			Own	Home
Maryland	should be filed within and Mental Hygiene. is marked other that aumatic event, the N	To Be	17. Father's Name (First, Middle, Last)	b Podietz			18. Mother's Nan		Maiden Surna Ca Hadl	-	
aryl	and Me is mar		19a. Informant's Name/Relationship (		19b. Mailin	g Address (Street a	and Number or Rui				Code)
	and 2 s Health em 27		Rita L. Luger -				vry Lane,				
Baltimore,	permit. Page 1 a Department of H Important: If ite any njury or ot		20a. Method of Disposition 1   Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Spec.	Removal from State Ce (fy) King	metery, crem David		idns 12/1		Falls		ch, Virginia
Bal	Deper Impor		21. Signature of Funeral Service Licen	itzenbilm 12	3 Z 1 1 1	. Name and Addres 800 New H	ss of Facility Hi Lampshire	nes-Rin AveS	aldi Fi ilver S	ıneral Sprina	2 Home, Inc. 1,MD 20904
	Physician/ Medical Examiner  the private private and the priva	Examiner	23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if a.y. bearing to minimal at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Coronar Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due to (or as a conseque to Due Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due Due to Due to Due to Due to Due to Due Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due Due to Due to Due to Due to Due to Due .	Artence of): uilure		-	or respiratory ar	rest,		Approximate Interval Between Onset and Death
3760	te be e nysiciai he buri	dical		d						$\longrightarrow$	
Box 687	ith certific ittending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1  Live Birth 2  Fetal 4  Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	ey .			Date of deliv	very Day Year
s, P.O.	res that the dea signed by the a d be detached i	d by Ph	Part II. Other significant conditions of Dementia	contributing to death but not resu	Iting in the u	nderlying cause giv	ven in Part I.				the cause of death?
of Vital Records,	The law require: ate has been signage 2 should l	Completed by						24a. Was auto perfo	psy ormed?	prior to co death?	opsy findings available ompletion of cause of
tal	ician: The certificate rector, paq	BeC	25. Was case referred to medical examiner?				ace of Death (Chec	_	2 No	1  Yes	2 L NO
f Vii	Physic this co	은	1 Yes 2 No	Hospital:  1 X Inpatient 2 E  28a. Date of injury	R/Outpatien	t 3 DOA Othe	4 🔲 Nursing H	ome 5 Resi			y)
on c	anding ath. rr. After he fune	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) n	injury	work		Zug. Describe i	now injury occ	arrod	
Division	al or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ne, farm, stre	et, factory, office		28f. Location ( City or Tox		nber or Rura	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check 2 Medical Exam	vsician: To the best of my knowle niner: On the basis of examination are Practitioner: To the best of my	and/or invest	igation, in my opinic	on, death occurred a	at the time, date a	and place, and	due to the ca	ause(s) and manner stated
	vithin To th		29b. Signature and title of certifier	A 0 110	,	29c. License			29d. Date sig		
			30. Name and address of person who	completed cause of death (Item)	23a) (Type P	rint)	DU 1-3	300 Va	n Dus	on Ri	oad
			Saritha Goranti	la MD Laure	el Res	iional Hos	spital L	durel,	MD		0707
-2	Sta Registra		31. Date filed (Month, Day, Year) 012	32. Registrar's Signatu	fax		1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 40322 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jean How Lee 1:40 am December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Nursing & Rehab Sandy Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 579-68-7846 Director 1 □ M 2 🛛 F 91 11/15/1921 China r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 3527 Tarkington Lane, 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force ģ 1 Never Married 2 Married Black White etc. ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: Completed Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 721 h and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Tai Lock Kum Cheun Lee. 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel Moy - Daughter 3527 Tarkington Ln.,#63A,Silver Spring.MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite eny injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 12/15/2012 | Silver Spring, MD 21. Signature of Funeral ervice Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure) List only one cause on each line. Immediate Cause (Final Onset and Death
Immediate Pnysician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Dav ate has been signed by the apage 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Renal Failure Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate Cardiovascular Accident 1 ☐ Yes 2 ☐ No reral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify, 1 Tes 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours at To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Pertifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur Schoengold, 31. Date filed (Month, Day, Year)

3 2012

M.D.,

32. Registrar's Signature

D0018726

18111 Prince Philip Drive, #T10, Olney, Maryland 20832

December 12, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 11, 2012 WILLIAM THOMAS LONDON 2:50 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Gilchrist Hospice Center Towson Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 499-24-7677 Director 1 **X** M 2 □ F Yrs 85 Dec 13, 1926 Texas r than "neture!", or items 23a or 28a-f show the Modes Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits Maryland Baltimore County 1 🗌 Yes 2 💢 No Glen Acm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11630 Glen Arm Road 21057 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 May Yes 2 □ No
If Yes, Give ģ 1 Never Married 2 Married Black, White, etc. 3altimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than US Public Health College (1-4 or 5+) 5 + Elementary/Secondary (0-12) Veterinary Director Services at NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be fil nt of Health and Mental : If item 27 is marked ( 2 Katherine Jane Maxwell Hoyt Hobson London 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 St. Francis Road, Greensboro, NC 27408 Bruce Alan London (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I Page 1 1 Burial 2 X Cremation 3 Removal from State ö Metro Crematory, Inc. 12/12/2012 injury 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Fundal Service 1 TO YORK ROAD, BALLIMOTE, MATYLAND 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physicien: The law requires that the death certificate be executed thin 24 hours after cleath.

the Funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Souther (Specify) 1 🗌 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier diress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 40324 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. 2012 James R. Lavey 8:15 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium 2414 Girdwood Rd. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Davs Hours Min. (Month, Day, Year) Director 336-12-2416 1 X M 2 □ F 87 Yrs Feb. 8 1925 TT. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f shov any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2414 Girdwood Rd. 21093 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 ☐ No If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Western Electric System Equipment Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Alice Tubman Jean C. LaVey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Girdwood Rd., Timonium, MD 21093 Rose N. LaVey 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial Cardens 12/15/12 Timonium, MD 21. Sign dure of Funeral Service Li 22. Name and Address of Facility Lemmon Funeral Home of Dulaney O W. Padonia Rd., Timonium, MD Michael 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause of each line. he mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final nd 500th (4) neumonitis Physician NOSSIVE disease or condition resulting in death) Medical or as a consequence of: Examiner omic Month S. cuintially list our diturns if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending iniury 1 Yes 2 No ccident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Funeral L Medical 29a. Certifier To the Hosp within 24 hou To the Funer completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License numbe 29d. Date si 10 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) ₹734 York Rd., Timonium, MD 21093 Richard L. Huslig, M.D. 31. Date filed (Month, Day, Year)
DEC 1 3 2012 32. Registrar's State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0105 AM Looper Jr Physician/ December 7012 James Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Seasons Hospice Northwest Hosp Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 577-66-4216 IA 63 1**X** M 2 □ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Director Prince George's Greenbelt item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Wedical Examiner must be netified 1 Yes 2X No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 20770 108 Lastner Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Sales Sales Be 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be filed.
Department of Health and Mental Emportant: if item 27 is many injury or other. 17. Father's Name (First, Middle, Last) Barbara Stivers James Donald Looper ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister 6309 Marywood Rd Bethesda MD 20817 Jennifer Vongsathorn 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition crematory 1 Burial 2 X Cremation 3 Removal from State Glen Burnie MD 12/04/12 Atlantic Crem 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun 21. Signature of Funeral Service Licens ThomasAllenPA 7090 Ridge Rd Hanover 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final lar Cerebnivascu Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death g 🗌 Unknown filled in by the funeral director, page 2 should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be examiner? Other:
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Nursing Home 5 
Residence 6 
Other (Specify) Hospital 2 No 1 Inpatient 2 ER/Dutpatient 3 DOA ၉ this 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Certificate: injury 1 🖪 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29d. Date signed (Month, Day, Year) Signature and title of certific December 22012 D0053337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 693,4 Boulevard Aviation Deay m.D 32, Register's Signature 31. Date filed (Month, Day, Year) State 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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andolph Murray		State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg.		32
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last)  2. Date of Death	3. Time of Dea	
		4a. Fability Name (if no finistitution, give street and number)  Sinai Hospital  4b. City, Town, or Location of Death  Baltimore	4c. County of Death	
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Maryland r 28a-f show any ed at once,	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  10e. Street and Number 10f. Zip Code 10g	10d. Inside Ci	•
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1036 within 72 hours iene er than "natur Medical Exami	Completed		6b. Kind of Business/Industry	
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Division of Vital Records, P.O. Box 6876C To the Hospital in Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be deached for use as the b	ΣI		23d. Date of delivery  Month Day Y	'ear
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	W	29b. Signature and title of certifier 29c, License number	29d. Date signed (Month, Day, Year) December 6, 2012	
21		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		
Sta Regist	ate rar			
DHMH 17 Rev 1/20	001	ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 40328 530 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4 Physician/ December 02. Alfred Ruiz Martinez 2012 2330 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2 Rockville Montgomery Shadu Grove Adventist Hospital N 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. Director December 193-30-3277 1 X M 2 □ F 72 08/15/1940 Pennsylvania Usual Residence of Decedent 28a-f show permit. Pege 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director North Potomac 1 Yes 2 No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20878 14961 Carry Back Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black White etc. 1 Never Married 2 X Married þ 21215-0036 1 X Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Mexican Specify. Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Printing Graphic Artist Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victoria Ruiz Cayetano Martinez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14961 Carry Back Drive, N. Potomac, Maryland 20878 Elizabeth Martinez - Spouse Baltimore, 72 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 12/12/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Simple Tribute Funeral & Cremation Center
1040 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licensee 23a. part 1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ multi orjan disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sucre Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consiguence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by carrinoi d 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident
☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 73826 9.05AL 12/03/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ametya, MD 9901 Medical Center Down, Rockering Myshal 20800 birendin 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d, per MD G93/12/13/12 trt State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 26 Michael Edward Miller 2012 10:10P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice of Columbia Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 578-56-9499 1 X M 2 □ F 67 Jan 6, 1945 England Usual Residence of Deceden or then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits fliad within 72 hours efter death with the Marylend Director 1 Yes 2 No Sykesville Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 695 Gaither Road 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) el Hyglena. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Paga 1 and 2 should be fliad wit Depertment of Health end Mantel Hygier Importent: If Item 27 is marked other 1 eny Injury or other treumetic event, Item. 12 Plant Operations Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Eugene Miller Peggy Gittens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Carone Miller (Spouse) 695 Gaither Road, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 11/28/2012 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Buan C Hauset MOOT64 PO Box 195 Sykesville, MD 21784 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition STAGE Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examine Due to (or as a consequence of) To the Hospitel or Attending Physician: The iaw raquires thet tha death certificete be executed within 24 hours aftar death.

To the Funeral Director: Aftar this certificeta has bean signed by the attanding physicien and complately fillad in by the funeral director, pega 2 should be dateched for use as the buriel-trensit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2/1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accider (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1/C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a d title of certifie 29c. License number 30. Name (nd address of person who completed cause of death (Item 23a) (Type, Print) . ABBAS 6336 SYED Q 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type of Print in Black Indelible Ink./Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 40330 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 7, 201<sup>Year</sup> Moffitt Doreen С. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 325-22-7200 Director 1 □ M 2 🗓 F 84 Yrs. March 12, 1928 Illinois 28a-f show 10a. State 10b. County 10c. City, Town or Location Injury or other traumatic event, the Medical Exprainer must be notified at 10d. Inside City Limits Director Maryland Silver Spring 1 X Yes 2 □ No Montgomery 10f. Zip Code 10g. Citizen of What Country? Funeral 14109 Burning Bush Lane 20906 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Office Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Manfred A. Johnson Ceceila Sternal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 E. Melrose St., Chevy Chase, MD 20815 Keith Korenchuk 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If it
any Injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lockport City Cemeter 12-19-12 Lockport, IL Sign ature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Year Pregnant at time of death 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) latel Layanti 1)0052586 В 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jayanti Patel 1500 Forest Glen Road Silver Spring, MD 20910 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#5 Per FH C935 / 11/2013 Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 40331 Decedent's Name (First, Middle, Last) 2. Date of Death Month Dec 5, 2012 Physician/ 8:50 P Eleanore M. Nadler Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 502 Anchor Dr. **Joppa** Secial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 1 M 2 XXF Yrs Sept 12, 1927 NY permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No Nassau Bethpage 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 211 Apollo Cr. 11714 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. <u>გ</u> 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes XX No Specify: Completed 3 XXWidowed 4 □ Divorced Specify: White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Assistant Vice President Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ <u>William Penney</u> Elizabeth Ellaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert G. Nadler 502 Anchor Dr., Joppa, MD 21085 Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dec 12, 1012 Long Island National Cem Pinelawn, NY 21. Signature of Funeral Service Ichas K. Gregory Fink 22. Name and Address of Facility Fink Funeral Home, P.A. M01148 426 Crain Hwy S., Clen Burnie, MD 21061 23a. Part 1. En er the dishase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Hit only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition a CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Exami for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death To the Hospital or Attending Physicien: The law requires thet the dea within 24 hours after death.
To the Funcerel Director. After this certificate has been signed by the e completely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) SONS RESIDENCE examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{\infty}\) Residence 6 \(\overline{\infty}\) Other (Specify) 1 Yes 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 ី Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature at 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 TRACIE L. MORGAN, 31. Date filed (Month, Day, Year)

TEC 1 3 2012 32. Registrar's Agnature

State Registrar

DECMEBER

ELEANORE NADLER

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 40332

		1- For State Certificate of Death Reg. No.	
Physicia	n/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day	3. Time of Death
Medical Examin		Brent Jay Nickens December 7, 201	12 1107 1118
		University Hospital Baltimore	County of Death NA
Funeral Director		5. Social Security Number 220-29-0745 6. Sex 12 Prs. 7. Age (In yrs. last birthday) 15. Social Security Number 220-29-0745 12 Prs. 16. Sex 15. Age (In yrs. last birthday) 22 Prs. 17. Age (In yrs. last birthday) 15. Months Days Hours Min. 16. Sex 16. Sex 17. Age (In yrs. last birthday) 16. Sex 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Date of Birth (MM/D	DD/YYYY) 9. Birthplace (State or Foreign Country) MD
Dre, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "matural", or items 23a or 28a-f show any her traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State	ten of What Country?  USA  14. Race - American Indian, Black, White, etc. African Specify: American Lind of Business/Industry unk.  Surname)  Todd  ty or Town, State, Zip Code)
Physician Physician Txaminer	1	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Wylie Funeral 638 N. Gilmor Street Baltimor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds Due to (or as a consequence of):  b.	re, Maryland 21217
760, cate be execu	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Was decedent pregnant in the	d. Date of delivery Month Day Year
cords, P.O. aw requires that the has been signed by 1 should be detached.	Completed by Physician		use contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  o 1 Yes 2 No
Tifica or, pa			
Vital Rec ysician: The I this certificate I director, page	o Be	1 Yes 2 No Presider 2 ER/Outpatient 3 DOA 1 A Nursing Home 5 Resider	ence 6 Other:
ion of vending Physical Acteut	⊢⊦	27 Manner of Death 128a Date of Injury 28b Time of Injury 128c Injury at Work? 128d Describe how injury	iry occurred
Division pital or Attendi urs after death. rral Director: A	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined (Specify) Local Street (Specify) Local Street 2300 Block of Westward (Specify) Local Street (	ind Number or Rural Route Number, City wood Avenue, Baltimore, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		
H × H 2	ž		Date signed (Month, Day, Year) cember 8, 2012
7	ŀ	30. Name and address of person who completed cause of death (Item 201)	
0	لِ	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Sta Regist	460	A COLOR OF THE COL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 10:27 A M O'Brien December Teresa Marie Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner North Bethesda Т3 Montgomery 11323 Commonwealth Drive, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Hours 577-40-3765 Director 1 □ M 2 🛛 F 84 New York September 20, 1928 f health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the <u>Medical Examiner must be notified at</u> 10d. Inside City Limits 10c. City, Town or Location 10h County 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No North Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral United States 11323 Commonwealth Drive, T3 20852 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) National Institutes College (1-4 or 5+) Elementary/Secondary (0-12) within of Health Secretary Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne) ပ D'Oria Marietta and 2 should be Ralph Acquaviva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4315 Avenida Lorenzo, #C, Oceanside, California 92057 Thomas R. O'Brien /Son or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Durial 2 Cremation 3 Removal from State Silver Spring, Maryland Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 15. 2012 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee mortette MAM M01305 23a. Part 1. Phter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MON LINS Immediate Cause (Final disease or condition Congestive Heart Failure Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine ending physician and use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ jo in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Records, After this certificate has been significate has been significated and all the standard of the 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔯 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Other: 4 Nursing Home 5 🕅 Residence 6 🗆 Other (Specify) 1 Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

20 V State

Registrar DHMH 17 Rev 06-2011 Dennis Cullen, MD 7625 Wisconsin Avenue, Ste. 101, Bethesda, Maryland 20814

D40216

December 11, 2012

ller

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alice Dorothea Van Over December 10,2012 10:35 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Westminster Carroll County Dove House Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year)
July 07, 1946 Days Hours Baltimore, MD. 214-46-9894 66 1 □ M 2 🖺 F Director Usual Residence of Decedent 28a-f shov 10b. County the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll County Hampstead 1 Yes 2X No 10g. Citizen of What Country?
United States 10e, Street and Number 10f, Zip Code 1207 Midvale Court 21074 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 6 þ 1 Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) N/A Home Maker Own Home Be other traumatic event, 18. Mother's Name *(First, Middle, Maiden Surname)* Lillian Bryant 17. Father's Name (First, Middle, Last) Michael S. Armetta 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 Is any Injury or other trau 21074 Mr.Stafford Ray Van Over, Jr. 1207 Midvale Court Hampstead, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name o ation 5 Other (Specify)

A Service Licens 2 Local Control Services, Inc.

1 Services Inc.

1 Services Inc.

1 Services Inc. 20c. Location - City or Town, Sta Harford County Friday 1 🗆 Burial 2 🖺 Cremation 3 🗆 Removal from State Dec.14,2012 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093-2215 21. Signatur Lic.#M00677 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final MARKINA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) g Unknown the detached Division of Vital Records, P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signe page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy hours after death. Ineral Director: After this certificate h 1 Yes 2 1 No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 🗌 Pending 1 Natural 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 24 hours Medical 🚅 🇲 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signatu nd title of certifie

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

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EVIER

ST WESTMINSTER, MI

pleted cause of death (ben 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 200 Month Proesche Dicemb 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 220-20-9132 Director 1 M 2 1 TE 83 Jan. 18, 1929 Baltimore, MD Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f s must be notified Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 8700 Cimarron Circle 21234 United States ural", or items ? should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) i Hygiene. State of Maryland Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mentai marked c ည William Becker Clara Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Proescher-8700 Cimarron Circle Parkville, MD 21234 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December permit. Page 1 and Department of I Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Parkville, Maryland Parkwood Cemetery 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville. 2 a. F. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Valvular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying signed by the attending physician and id be detached for use as the burlal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I 1 Tes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) ၉ 1 Yes 1 Inpatient 2 ROutpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bathmore Roven Bluch 5601 Loch State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Month Physician/ 8:53 Katherine Perrear 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL AGNES BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 11-06-33 Director 231-40-6758 VA 1 □ M 2 🗓 F 79 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland rel", or items 23e or 28e-f sho Examiner must be notified at Director 1XXYes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 1018 Lyndhurst Street USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African "neturel", or Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ☐ Yes 2 No Specify Specify: American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Memorial Stadium Supervisor 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Virginia Smith Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Stonecroft Road Baltimore, Maryland 21229 Virginia Denise Jones-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Mem. Pk. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 12-15-12 Arbutus, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

D 446 Immediate Cause (Final LIKELY LOLITIS Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): DISEASE RENAL Examiner YEAR STAGE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence Exami DIMBETES 4*E1*12 To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month or: After this certificate has been signed by the a the funeral director, page 2 should be detached the Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funerel Director: A
completely filled in by the f Accident Investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 nd address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD, 21229

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

CATON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of Maryland State of Maryland Registrar		artment <i>tificate</i>			and M		giene Reg. No	ZU	12	40337
Н	Physicia	ın/	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	у <b>т</b>	Year	3. Time of Death
	Medic	al	MABLE PARKER  4a. Facility Name (if not institution, give street and number)		4b. City, To	own or	Location	of Dooth	Month \ 2	-		12	1226 A M
w	Examin	er	MERCY MEDICAL CENTER		_		ORE	or Death		40.	County	of Death $N_{ m J}$	/A
F	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) 2 Yrs.	If Under 1 Months		If Under Hours		8. Date of Birt 0 9 7 1, 7		10	9. Birthp	lace (State or Foreign arolina
	nd how at	<u>_</u>	Usual Residence of Decedent  10a. State 10b. County 10c. City.	Town or Loc	cation							1:	0d. Inside City Limits
	//arylar 8a-f si tified	Director	37/3	timo									1 XYes 2 No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	eral Di	10e. Street and Number 1131 Ashburton Street		10f. Zip (					10g. Cit	izen of	What Coun	try?
	eath w tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decede Yes, specif	nt of His	spanic Orig	gin? (Spec	ify Yes or No-			ce - America	an Indian,
36	after d al", or i xamin	by	1 Never Married 2 Married 1 Yes 2 No 1 Yes, Give Year or Dates.		Yes 2				ican, etc.,			ck, White, $\in$ Bla	
2-00	hours 'natur dical E	olete	real of Dates.	16a. Deced	lent's Usual	Occupa	tion	of working	7	16b. K	ind of B	susiness Inc	lustry
121	ithin 72 ene. • than ' the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)		O NOT use r		ing most	. OI WOIKII	9	s.	S.A	. •	
nd 2	filed wall Hygi dother vent, t	Be	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle,	Maiden	Sumam	e)	
ryla	uld be d Ment marker natic e	J.	Oscar J. Brown						Favo		_		
Baltimore, Maryland 21215-0036	nd 2 sho ealth and n 27 is r er traun		19a. Informant's Name/Relationship (Type, Print) Anthony Parker (Son)	19b. Mailin 1141	Ashk Ashk	Street ar Surt	nd Numbe	ar or Rural Ave •	Balt Balt	r City or imo:	re,	MD C	2°f 216
ore	ge 1 ar of He i: If iter or oth		1X Burial 2 Cremation 3 Removal from State	ce of Dispos	natory or oth		e)		5/12			- City or To	
altin	mit. Pa partmen portant injury		4 ☐ Donation 5 ☐ Other (Specify)	g Pa		Apldres							Mill, MD
Ä	permi Depar Impor any ir		ietich N. William	Ze Z	140 I	V . 1	rult	on A	ve. B	alt.	imo	re,	MD 21217
404.	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		r the mode					rest,			Approximate Interval Between Onset and Death
the state of	Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence)		( AL		100					-	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nce of):									
8	ecuted and -transit	xam	Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of the	nce of):									
% %	cate be executed physician and s the burial-transit	dical Examine	d.										
928	rtificate ing phy e as the		IF FEMALE:										
Box 687	eath certificat attending ph I for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	death 3 🗌	Ectopic pr Other (spe		1			Ì		ate of delive onth	ery Day Year
	the de by the tached	hysi	9 Unknown 9 Unknown										
Division of Vital Records, P.O.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transitions.		Part II. Other significant conditions contributing to death but not result  EMPHJ SEMA	ing in the u	nderlying ca	use give	en in Part I		23e. Did to		_		e cause of death?
ord	w requisite been 2 should	Completed by	PERIPHERAL VASCILAR DIS	FASE					24a. Was				osy findings available mpletion of cause of
Rec	The la	Com	DIABETES						perfo	rmed2 2 N		death?	15(4)
/ital	sician; certifi	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: Hospital:	D/Outmation	+ 2 \( \tau_{\text{DO}}\)	Othou	r: _	th (Check o		,		(Cif-)	
of \	ng Phy fter this neral d		The impation 2 D E	8b. Time of injury		c. Injury work?	at		ne 5  Resid 3d. Describe h				,
sion	ttendii death. stor: A: / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e farm etre	M eet factory		Yes 2 🗆	_	8f Location /9	treet on	d Numb	er or Rural	Route Number,
Divi	tal or A rs after al Direct		4 Homicide determined 28e. Place of Injury - At nom building, etc. (Specify)		oci, radiory,	011100			City or Tow			- Triarar	riodio rearriso,
	To the Hospital or Attending Physician: The law requires that the dewinthin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the accompleted filled in by the funeral director, page 2 should be detached	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowled only one) 3 Certifying Nurse Practioner: To the best of my knowled	and/or invest	igation, in m	y opinior	n, death oc	curred at t	he time, date a	ind place	, and du	ie to the cau	use(s) and manner stated.
_	To the vithin To the comp		29b. Signature and title of certifier		29c.	License	number					d (Month, E	
	8		30. Name and address of person who completed cause of death (Item 2	39) (Time 1		643	• <del>+</del>			12	717	2012	
	O	'	DAVID A. VITRERY MD 345	2+	· PAUL	PL	. B	ALTIA	MORE	MD	<b>.</b>	212	202
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 40338 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Robert Peter, III December 6, 2012 12:54 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) 577-42-3075 80 Director 1 ፟M 2 □ F Nov. 23, 1932 Washington, D.C. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Montgomery Village 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20886 19400 Faber Court United States death \ 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: than "natural", Completed 3 Widowed 4 K Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Safety Director Montgomery County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ည Mary Fackler Tyler Robert Peter, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 18913 Tributary Lane, Gaithersburg, Maryland 20879 Robert Peter, IV/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December Montgomery 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12, 2012 Crematorium, Inc. 21. Signature of Funeral Se Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?

1 Yes 2 No Year Pregnant at time of death the g Unknown 9 I Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has te 2 autopsy , page LECCED WA 2 1 No certificate 1 Yes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer (Month, Day, Year) 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State

Registrar DHMH 17 Rev 06-2011 3 🗆

31. Date filed (Month Day,

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

600

29d. Date signed (Month,

Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	4	For State		State	of Ma	arylan					and M	Mental Hy	giene	9			000
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Physicia				1 Puglia								Decembe		<sup>py</sup> , 20	1 <sup>Year</sup>	1	O PM
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Funeral Director		5. Social Security No. 029–18–22		6. Sex	_	(In yrs. Ia 89	st birthday	Months		If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)		Cou		
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To the Hospital or Attending Physician: Tha law raquiras that the daath certificata ba within 24 hours after daath.  To the Funeral Director: After this cartificata has been signed by the attending physici compiately filled in by the funeral director, page 2 should be datached for use as the but a funeral director.	Medical	(Check 2	2 Medical E	Physician: To the Examiner: On the b	asis of ex	xaminatio	n and/or in	estigation, i	n my opinio	on, death o	ccurred a	at the time, date	and plac	ce, and du	ie to the c	ause(s) and m	anner stated.
To the within To the Compi	Σ	only one) 3 29b. Signature and			er: 10 trie	e Dest Of I	ny knowiec		9c. License		ile and pi	ace, and due to				, Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBE Bernadette Riley Helen Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMOR SAINT JOSE 8. Date of Birth (Month, Day, Year) Jan. 20, 1934 Social Security Number Birthplace (State or Foreign Country) Funeral 214-30-5603 Hours Director 1 🗆 M 2 🔀 F 78 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 21 No Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3705 Foxford Stream Road 21236 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: white 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Catholic Charities Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur Kinsella Bridget Agnes Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, John Riley-son 121 Mica Drive-Westminster, Maryland 21158 20b. Place of Disposition (Name of cemetery, cremetory or other place St. Joseph Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State Dec.14,2012 4 ☐ Donation 5 ☐ Other (Specify) Fullerton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and 8800 Harford Road- Parkville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAC Physician/ RE AND HEMORRHAGE disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and EROTIC CORDNARY YEAKS Physician/Medical SEASE IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Fctonic pregnancy Month Pregnant at time of death 5 Other (specify) Day signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, | 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown tor: After this certificate has been sittle funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ¥ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be To the Funeral Direct completely filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗍 Certifying Nurse Practitioner: To the hest of my knowledge, death postered at the time, date and place, and due to the named and manner as etaled only one 29b. Signature 29d. Date signed (Month, Day, Year) PATITOLOGIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER STEVEN R M.D. TOWSON, MARYCAND 21204 DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of M	arylan	-	artmen <i>tificati</i>			and M			e .20	12	40	341
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	Funeral Director		5. Social Security Number 215-01-803	6. Sex	7. Ag	e (In yrs. la 94	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)				or Foreign
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р.ш. .0036	permit. Paga 1 end 2 should be fliad within 72 hours after death with the Maryland Important of Heath and Mantel Hyglane. Importent: If the 27 is merked other than "natural", or items 23e or 28a-f show eny injury or other traumetic event, the Medicel Examiner must be rottlind at once.	þ	1 Never Married 2 3 Widowed 4 Di	☐ Married	Armed Forces? 1 ☐ Yes 2X☐ If Yes, Give Year or Dates.		"	Yes, spec	ify Cubar	n, Mexicar	n, Puerto F	Rican, etc.)		Black	k, White, e Whi	tc.	
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2012 aryland	nd Mar s merk umetic		19a. Informant's Name/Rei		e, Print)		19b. Mailin	g Address	(Street a			Route Numbe	er, City o	or Town, Si	ate, Zip C	ode)	
10,	nd 2 si leaith a m 27 ii		James Roe		Son					oury	Lan	e Fal		<u> </u>			7
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- 8	Medical Examiner		resulting in death)	ſ	Due to (or as	a consequ	ence of):										
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	With:	_	29b. Signature and title of o		01.10				License		21			ate signed			
	,_		30. Name and address of p	person who cor	mpleted cause of o	leath (Item	23a) (Type. P	rint)	5/9	9/	16	1	12	110	1201	_	
	Q		JACKIE JONE	S, CRN	P 2300 1	DULAN	EY VAL		D.	TIMO	NIUM,	MD 21	093				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $L \cap 3L$ Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Christine Ross 18 2012 1:42 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/ABaltimore 2236 Penrose Ave. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 06/07/1923 Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours Min. Days 220-18-4997 89 Yrs. Director 1 □ M 2 🗗 F er then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours efter death with the Meryland Director N/A Baltimore MD 1 XYes 2 No 10f. Zip Code 21223 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 2236 Penrose Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ٥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Haelth end Mentel Hygiene.
of Haelth end Mentel Hygiene.
If Item 27 is marked other then "" Merchant Club Elementary/Secondary (0-12) College (1-4 or 5+) Waitress 8th 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Burse Lucy Akins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2236 Penrose Ave. Baltimore, MD 21223 Lucy Meekins (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Pege Department Importent: If eny injury or once. Baltimore, MD On-Site Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service License 22 Name and Hidress of Facility Own Jr. Funeral Home PA MD 21217 amo 2140 N. Fulton Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acura Physician/ M40 C4 IN AHONON disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ATTHE POSCUETOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physicien and s the burial-transit イナイ アンアー しみのいころんでかい Hospital or Attending Physician: The lew requires that the deeth certificats be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 15-MG10 N attending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year sate has baan signed by tha a page 2 should be detached t Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 仑 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N To the Hospital or Attending Physician: The within 24 hours at the Gean. To the Funeral Director; After this certificate it completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 🗌 Nursing Home 5 💆 Residence 6 🗍 Other (Specify) 1 🗌 Yes 2-DNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certifi

Registrar
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address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatu

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 07. Physician/ 8:30 ам Rebecca E. Rieger 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chevy Chase Montgomery 8100 Connecticut Avenue, #1221 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days **Director** 579-22-8175 1 □ M 2 K I F 02/21/1921 New York ıtal Hygiene. əd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 💢 No Maryland Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 8100 Connecticut Avenue. #1221 20815 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Washington School of Elementary/Secondary (0-12) College (1-4 or 5+) Clinical Psychologist 5+ Psuchiatru Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I Leah Temkin Leo Eisenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Passeig De Sant Gervasi #71,3-1, Barcelona, Spain Deborah Bonner - Estate Exec. Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any Injury or of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns: 12/13/2012 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. . MO1355 21. Signatore of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the discussed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hepatic Cirrhosis disease or condition Medical resulting in death) Examiner Primary Biliary Cirrhos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aortic Stenosis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending the Funeral Director... 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 07, 2012 D55258 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) 9707 Old Georgetown Road, Bethesda, Maryland 20814 Gary Wilks M.D.,

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)
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	20tl)		30. Name and address of person w	who completed causes	of death liter	23a) (Tuno		38781			NOVE	MREK	16, 20	12
Y			MICHAEL J. GRA	DY M.D., 4				JE. NW	<b>,</b> #1	14, WASH	IINGTON	D.C	. 2001	6
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Registrar Certificate of Death 2. Date of Death 3 Time of Death Month 12 Physician/ Matthew 8:05 AM Simmons Jr. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 4913 Enterprise Road Bowie 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Ye 1 XM 2 ☐ F Months Davs Hours Min. , 1942 South Carolina Aug. 248-58-5204 70 **Director** Usual Residence of Decedent 10d, Inside City Limits 10a, State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director ms 23a or 28a-f s must be notified 1 Yes 2 No Prince George's Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4913 Enterprise Road 20720 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Isonce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Truck Driver Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rebecca Colleton Matthew Simmons Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20720 4913 Enterprise Road, Bowie, Ella D. Simmons/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 12/14/2012 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. Si nature of Funeral Service Licensee 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Late Effects of Cerebrovascular Disease 3months disease or condition Medical resulting in death) **Examiner** Adult Failure to Thrive lmonth Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
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5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown 9 T Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 M Unknown Vascular Dementia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Functional Diarrhea autopsy death? 1 Yes 2 No Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 👿 No 1 🗌 Yes ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Inpatient 2 I To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number D0040904 December 11, 2012 ted cause of death (Item 23a) (Type, Print) B 30. Name and address of person who comple 1209A Marda Lane, Annapolis, MD 21403 Nancy D. Rivera King, MD

DHMH 17 Rev 7/2009

State

Registrar

NFC

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	
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tendin leath. tor: Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r	gation		injury		? Yes 2□N	0				
al or At s after o		4  Homicide determi	ined 28e. Place	of Injury - At hor ng, etc. (Specify)	ne, farm, stre	et, factory, office		2	28f. Location (St City or Town		er or Rural F	oute Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Ex	Physician: To the base xaminer: On the base Nurse Practitioner	sis of examination	and/or investi	gation, in my opinic	n, death occu	irred at t	the time, date an	d place, and du	e to the caus	e(s) and manner stated.
Tot COT		29b. Signature and title of certifier	2	-	-	29c. License		1		9d. Date signe		_
2		30. Name and address of person w	vho completed caus	se of death (Item	23a) (Type, Pr	rint)	55861	7	300 Va	n Dus	en Ro	8, 2012 ad
State	9	Abdul Munim, 31. Date filed (Month, Day, Year)	MD [	_aure( egistrar's Signatu	Region	nal Hosp	pital	L	_aurel,	MD	20'	10'1
Registra		DEC 1 3 2012	General		barke	9				-		
	244		-	· •								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 40348 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 1 12, 2012 Edith Wilson Storm 11:37 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1807 Ridgeway Avenue Lutherville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 1 □ M 2XXF Director 215-18-6735 90 Nov. 12, 1922 n of Health and Mental Hygiene.

If item 27 is marked other then "natural", or items 23a or 28e-f shov or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1807 Ridgeway Ave. 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 27. No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes XXX No Specify. 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Coflege (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked oft any injury or other traumatic even 20xe. 18. Mother's Name (First, Middle, Maiden Surname) Maurice Eugene Dixon Edith Rowe Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger L. Storm, Jr. (Son) 1875 Roque River Circle, Ventura, CA 93004 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem'l Grdns 12/15/2012 Finksburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ YEORS Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an B B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Mann of Death 28b. Time of 28c. Injury at Nature 2 Cident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and titl 29c. License number D29373 ss of person who comp of death (Item 23a) (Type, Print) SUITE 200 LUTHER VILLE MO 21693 30. Name and add T. SETTER 755 State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of N	/larylar	na / Depa <i>Cer</i>	tificate of	Health Death	and Mental		ene 20   a. No.	2	4034	9
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	Medic Examin		4a. Facility Name (if	f not institution, give	street and number)			4b. City, Town, o				4c. County of	Death		_
	Funeral		5. Social Security N		7. A	ge (In yrs. I	last birthday)	GLEN BU If Under 1 Year	If Under			ANNE AR		L lace (State or Foreign	7
	Director		214.66.30 Usual Residence	1	□м 24 г	60	Yrs.	Months Days	Hours		th, Day, Yo _ <b>1, 1</b>	ear)	Count		
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	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status		12. Was Decedent Armed Forger 1  Yes 2	Ever in U.S		as Decedent of I	lispanic Ori an, Mexicai	igin? (Specify Yes on, Puerto Rican, etc	r No-	14. Race -	America		_
036	s after ral", or Exami	ed by	1 ☐ Never Marr 3 ☐ Widowed	ried 2  Married 4  Divorced	1 Yes 2 I If Yes, Give Year or Dates.	No	1	☐ Yes 2XX No	Specify	;		Ci6	HITE		
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Baltimore,	je 1 and t of Heal if item 2 or other		20a. Method of Disp	osition X Cremation 3	Removal from Stat	20b. F		sition (Name of atory or other pla	ce)	Date	20	c. Location - Cit	y or Tov	vn, State	
Ħ	permit. Page 1 a Department of I Important: If ite any injury or of		4 Donation	5 Other (Specify	)			EMATORY IN	_ i	12.12.2012	BA	LTIMORE,	MD		_
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sion	vttendir death. ctor: Af y the fu	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not be				M 1 🗆	Yes 2						_
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_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1. (Check 2	Certifying Phys	cian: To the best o	f my knowl examination	ledge, death or n and/or investi	ccurred at the time	e, date and	place, and due to	the cause	(s) and manner a	s stated	d. se(s) and manner state	ed.
	o the l	ğ	only one) 3 29b. Signature and	Certifying Nurs	Practitioner: To the	ne best of n	ny knowledge,	death occurred at 1	the time, da	te and place, and du	e to the c	ause(s) and manr . Date signed (M	ner as sta	ated.	_
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	2		30. Name and addre	ess of person who co	ching 16	- 13	63 K	int)	14	215	31(	Cesar S.	inta	- Maria)	
	Stat Registra	_	31. Date filed (Month	1 3°2012	32. Registr	rar's Signat	park	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:05 PM Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death stow Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. Date of Birth Birthplace (State or Foreign Country) Months Hours (Month, Day, Year) 239-92-9075 Director 1 🗷 M 2 🗆 F 58 01/21/1054 North Carolina 10a, State 10b. County 10c. City, Town or Location with the Marylend 10d. Inside City Limits Director ms 23a or 28a-f sl 1 X Yes 2 No MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 N. Woodington Road 21229 U.S.A ir than "natural", or items filed within 72 hours after death 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) \$ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Forklift Driver Warehouse Be 17. Father's Name (First, Middle, Last) end Mental H 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 end 2 should be fill tment of Health end Mental tant: if item 27 is marked < မ Hugh Britt Alene Sears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Hill / Daughter Woodington Road, Baltimore, MD 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I important: if ite any injury or ot once. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 K Donation 5 ☐ Other (Specify) Anatany Gifts Registry 12/10/2012 | Hanover, Maryland 21. Signature of Funeral Service Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ettending physician end for use es the burlat-transit Hospital or Attending Physician: The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day ete hes been signed by the page 2 should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete 2 No 1 Yes Division of Vital director 25. Was case referred to medical æ 26. Place of Death (Check only one) ျှ 1 Yes 2 XNo Other: in 24 hours efter death.

he Funeral Director: After this constelly filled in by the funeral directions. 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune

completely f 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of certifie 29b. Signature and tit 29c. License numbe 29d. Date signe 2012 0 son who com 32. Registra State Registrar

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	Examin	er	, , , , ,	, 3		4b. City, Town, or		Death		County of Death		
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<b>.</b>	or ite	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 X</li></ul>	12. Was Decedent E Armed Forces? Married 1 ☐ Yes 2 🛣		Was Decedent of H If Yes, specify Cuba	ispanic Origin in, Mexican, P	Puerto Rican, etc.)	10-	<ol> <li>Race - Americal Black, White,</li> </ol>		
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	To the footpital or Atending Physician: The law requires that the death certificate, within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Ž	only one) 3ertify 29b Signature and title of cert	ying Nurse Practitioner: To the	best of my knowledge	, death occurred at t	he time, date a	and place, and due	to the cause(	s) and manner as	stated.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40352 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Morth 200 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2 Warren Lodge Court, Apt. Cockeysville Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs **Funeral** Hours **Director** 218-72-1019 1 🗆 M 2 🗶 F Yrs. Sept 2, 1958 53 Maryland or 28a-f show notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Tes 2 X No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be a once. Funeral 2 Warren Lodge Court, Apt. 21030 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married ģ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Caregiving n/a Caregiver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Evan Wheeler Lillian Virginia Leroy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a. Informant's Name/Relationship (Type, Print) Lillian Connor/Mother Warren Lodge Court, Apt. 1B, Cockeysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/12/2012 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland f fun ry Wice License 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Bryan W. Clary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ e to (or as a con quence of) disease or commu Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy been signed by the atter should be detached for in the past 12 months? Year Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 a performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only on examiner? 2 Z No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 124 hours after death. Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of

DHMH 17 Rev 06-2011

State Registrar who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ,30P M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🛣 F Months Days Hours Pennslyvania 09/08/1918 220 16 3558 94 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21227 U.S.A. 3308 Benson Avenue Apt. 234 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Casguer Woolworths year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Lizor Rose Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Shewbridge / Daughter 927 Rustling Oaks Drive Millersville, MD. 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 12/14/2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. . Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Pm 1. Enter the disease, or open plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final D e o (or as a consequence of): Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and attending physician Physician/Medical Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown page 2 should be detached Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗌 No 1 🗌 Yes Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work 5 Pending 2 Accident after death. 2 No Investigation the 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Bev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <u>Laura M. Semelsberger</u> Medical 2012 :20PM M Decembe Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1923 Everglade Court Crofton Anne Arundel Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. Days (Month, Day, Year) Hours **Director** 220-56-8561 1 M 2 X F Usual Residence of Decede September 16, 1947 Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Eventiner must be notified at hours after death with the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No Florida Charlotte Rotonda West 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25 Mariner Lane 33947 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 should be filed within 72 hours aft. and Mental Hygiene. Is marked other than "natural", 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Funeral Director Funeral Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John C. McPhearson Bernyce Marian Harrison permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen J. Semelsberger/Husband <u> 25 Mariner Lane, Rotonda West, Florida 33947</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State December 4 Donation 5 Other (Specify) Monica Cemetery 13, 2012 Berwyn, Pennsylvania Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cervical Small Cell Carcinoma Chronic Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ate has been signed by the attending physician and page 2 should be detached for use as the burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🕅 No Hospital: Certificate: To Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Home 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature nd title of cer

17

DHMH 17 Rev 06-2011

State Registrar Nicholas

31. Date filed (Month; Day, Year)

J.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Ferrell

67258

9707 Medical Center Drive, #300, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

December 10, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 William Clarkson Stuart III December 8:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Rockville Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months (Month, Day, Year) Davs Hours Min. Director 227-20-2289 1 🕅 M 2 🗆 F Yrs. 86 Virginia May 25, 1926 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Directo 1 Yes 2 No Silver Spring Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 #931 3330 North Leisure World Blvd., United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married 2 Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Real Estate Realtor Broker Be 18. Mother's Name (First, Middle, Maiden Surname) Should be file.
and Mental H
is marked off 17. Father's Name (First, Middle, Last) ပ္ William Clarkson Stuart Susan Reid Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other treu 3336N.LeisureWorld Blvd., #931, Silver Spring, Maryland, 20906 Patricia M. Stuart / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December Monigomery
Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State 12, 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Li utoral Survisa Lice Robert de Address Manylarey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ardionyopath Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag Yes 2 C 1 Tyes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) BB examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Béath 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

Veirs

29c. License number

D64624

29d. Date signed (Month, Day, Year)

Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER HOWARD SCHEVITZ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAL HOSPITAL OF BALTIMORE BALTIMORE N/ASocial Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min. (Month, Day, Year) Director 262-40-0837 1 🛛 M 2 🗆 F 08/04/1928 Usual Residence of Decedent 10c. City, Town or Location iral", or Items 23a or 28a-f sho 10d. Inside City Limits Director 1 Tes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 6 THOMAS CRADDOCK COURT 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Ŕ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CUSTOMS BROKER FOREIGN TRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 SCHEVITZ ROSE HINDIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 MURIEL SCHEVITZ/WIFE THOMAS CRADDOCK COURT, BALTIMORE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State בַ ס 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM:12/12/2012 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the rnode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line nset and Death Immediate Cause (Final Physician/ plon cance disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit Cause (Disease or injury Physician: The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed?

1 Yes 2 No 1 Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours efter death, (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practition. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certification of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month DECEMBER 09 2012 Physician/ 02:30P M SIROTA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES 3490 LAUREL DRIVE INDIAN HEAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. (Month, Day, Year) Director 217-14-6883 1 M 2 X F 89 03/30/1923 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Paga 1 end 2 should ba filed within 72 hours after death with the Maryland Director 1 Yes 2 1 No MD CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20640 3490 LAUREL DRIVE USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural" 3 ☑ Widowed 4 ☐ Divorced Year or Dates 27 is marked other than "nature treumetic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) and Mental Hyglana. PROPRIETOR **HARDWARE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည KOHN LILLIAN MONTALTO SAMILET. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 24760 LONG ROAD, CLEMENTS, KAREN THEDFORD/DAUGHTER MD 20624 Hem 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH I SAAC
ADATH I SRAEL 20a. Method of Disposition 20c. Location - City or Town, State parmit, Paga 1
Department of
Important: If it
any injury or o ō 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/12/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Cicensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diNOCA RCHEMA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ettanding physician end for usa es tha burial-transif Hospital or Attending Physicien: Tha law raquires that the daath cartiflceta ba axacutad that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificete has t diractor, paga 2 s autopsy **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 110 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No within 24 hours aftar daeth.

To the Funeral Director: Air completaly fillad in by tha fu Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nørse Fractifioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar of person who comply

31. Date filed (Mohth, Day Year) NFC 1 3 2012 ed cause of death (Item 23a) (Type, Print)

32. Registrar's

c35

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20a, 22per FH, G934, 12/15/2012, WS
State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:02 PMM 20T2 Howard H. Stamper November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 10535 York Road #102 Cockeysville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 327-22-3985 **Director** 1 X M 2 🗆 F Nov 5, 1925 87 Missouri 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director I Higiene. other than "natural", or items 23a or 28a-f sl vent, the Medical Examiner must be notified. ¹√ Yes 2 □ No MD Baltimore Cockeysville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10535 York Road #102 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. q 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: white 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) e 1 and 2 should be filed within 7 t of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the M College (1-4 or 5+) horse groomer animals Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Howard Stamper permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Dillion/friend 1830 Fairview Road Glenmoore, PA 19343 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🍊 Cremation 3 ☐ Removal from State Atlantic Crem Glen Burnte MD 4 Donation 5 Other (Specify) in 12-12-12 22. Name and Address of Facility Simplicity Cremation and Funeral State Anatomy Board 655 W. Baltimore Street Alt. Baltimore, MD 21201 7090 Hanover Kidge Rd. Hanover Signa of Funera Pervice License-23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ARTON disease or condition COLOWAM Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day signed by the a d be detached f Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown HYPSATENILA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 06-2011

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MM

A. Di Gewoln

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Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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Vente lel

12-6.10

h Thomas Me MAD 21097

12-09124 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Henry Smith State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 1, 2012 Henry Smith **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NB 295 north of 695 Linthicum Anne Arundel 5. Social Security Number 6 Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 212-33-0790 Director 04/21/1941 1 XM 2 F 71 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location MD Howard Annapolis Junction tem 27 is marked other than "natural", or items 23a or 23a-f sho traumatic event, the Medical Examiner must be notified at once. within 72 hours after death with the Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20701 USA 11035 Guilford Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, is marked other than "natural", or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: b 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7. Department of Health and Mental Hygiene. Laborer Paving 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Mabel Sims Edward Smith 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9198 Springhill Lane Greenbelt MD 20770 Lavinia Cox Daughter If item 27 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 12/07/12 Glen Burnie MD Atlantic Crem Donation 5 Other Specify: 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 10ms 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Medica a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ned for use as the burial - transit vsician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown

Division of Vital Records, P.O. Box 68760, within 24 hours a To the Funeral

Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in	Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26.Place of Dear	th (Check only one)
	spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	Nursing Home 5 Residence 6 🗹 Other: Scene
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury   28b. Time of Injury   28c. Injury at Work   FOUND:   Dec 1, 2012   0305 hrs   1   Yes 2	Pedestrian struck by auto
3 Suicide 6 Could not be determined	28e Place of Injury - At home farm street factory office building	etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) NB 295 north of 695, Linthicum, MD
29a Certifier	: To the best of my knowledge, death occurred at the time, date and	place, and due to the cause(s) and manner as stated.
one) 2 Medical Examiner: 0	In the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c, License numb	er 29d. Date signed (Month, Day, Year)

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

0315 hrs

Foreign Country)WashDC

Black

10d. Inside City Limits

1 Yes 2 No

Approximate Interval Between Onset and

Death

Year

Day

December 1, 2012

31. Date filed (Month, Day, Year) State Registrar

Ana Rubio M.D., Ph. D.

2. Registrar's Sign ture

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 8,20c, per fh, g934 12–12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Menth DECEMBER Day 05 2012 Physician/ 06:51A M TROXEL LUCY REYNOLDS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUNRISE OF PIKESVILLE BALTIMORE PIKESVILLE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Country Director 578-72-7633 1 □ M 2 🖾 F <del>5</del>/1913 99 05/1PHILIPPINES Usual Residence of Decedent 23e or 28a-f show if Health end Mentel Hygiene. Item 27 is merked other then "neture!", or items 23e or 28e-f show other treumetic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland Director 1 🗆 Yes 2 🔯 No ABINGDON MD HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 TIREE COURT, #403 21009 USA permit. Page 1 and 2 should be filed within 72 hours after deeth \
Department of Health end Mentel Hygiene.
Importent: If item 27 is merked other then "neturel", or items eny Injury or other treumetic event, the Medical Examiner my once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: WHITE Completed 3 X Widowed 4 □ Divorced res, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ REYNOLDS ROMIETTA REDMAN ROYAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROY TROXEL/SON TIREE COURT, #403, ABINGDON, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of Date UNK 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Myer, VA 4 ☐ Donation 5 ☐ Other (Specify) RLINGTON NATIONAL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Pin 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospitei or Attending Physicien: The lew requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Dav Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6. Nother Specify Hospital: Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Director: A Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and/or investigation is according to the cause of examination and or investigation and o 29a. Certifier 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Decrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certify 29d. Date signed (Month, Day, Year) U on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per 31. Date filed (Month, Day, Year)
BEC 1 2 2012 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40361 Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Dec. Leonard H. Tawney 12, 10:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Carroll Examiner 4b. City, Town, or Location of Death 3329 Old Westminster Pike Finksburg 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 214-14-7430 1**X**XM 2 □ F 90 Jan. 2,1922 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Tes ZYNo MD Carrol1 Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3329 Old Westminster Pike 21048 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? XX Yes 2 ☐ No Black White etc. 5 1 Never Married 2 Married 1 ☐ Yes XIX No Specify: I Hygiene. other than "natural", Specify: XXWidowed 4 Divorced White Year or Dates. WW II Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Well Drilling 9 <u>Well Driller</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any Injury or other traumatic ever Mental Benson Tawney Virgie Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David L. Tawney / 3329 Old Westminster Pike, Finksburg, MD 21048 Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evergreen
Memorial Gardens 20a Method of Disposition 20c. Location - City or Town, State Date XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/15/12 Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitEckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Aspiration Pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Cause (Disease or injury Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2XXNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XXNo 1 ☐ Yes 2 ☐ No 1 🗀 Yes 25. Was case referred to medical examiner? B B 26. Place of Death (Check only one) 2X XNo Hospital Other: 1 🗌 Yes မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5XX Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier Danswriga, MD D0051705 December 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Vital

Division of

Registrar NFC

31. Date Month, Day, Year)

Mayan Pansuriya MD.

349 Malcolm Dr. Westminster MD 21137

		-	For State	Pleas amend	se Type or Pr #7 Per FH G amend	int in E 1934   Paryland 18, per	Black Ir 2/13/2 fh.g	ndelible In 2012 JH 2014 Of J 234 12-18	k. Ens Health 3–12 s	and M	ental Hy	aiene	e Legil		403	62
	Physicia	n/	Registrar  1. Decedent's Name  MAB	e (First, Middle,			Cer	uncate or i	Deam		2. Date of De	eath	<u>ا کی تا</u> 2012 ک		3. Time of Do 1:00 A	eath
	Medic Examin		4a. Facility Name (if	not institution,	give street and number)			4b. City, Town, o	or Location of	of Death			. County o		1200	
	Funeral		FUTURE  5. Social Security No	CARE OL		ge (In yrs. la	st birthdav)	RANDA If Under 1 Year	LLSTO		8. Date of Bir	rth '		'IMO	RE lace (State or F	oroian
	Director		217-18-3	146	1 DM OFF	88	Yrs.	Months Days		Min.	(Month, Da	y, Year)	1	Coun	ry)	
	show dat.	ö	Usual Residence of 10a. State	of Decedent 10b. County	]		, Town or Lo			<u> </u>	2-7	2	(4)		SncuTA Od. Inside City	
	Maryla 28a-f	Director	MD	BALTI	MORE	R	RANDALI	LSTOWN							Yes 2	□ No
	th with the Maryland ms 23a or 28a-f sho must be notified at		10e. Street and Nun		RD. APT. (	2		10f. Zip Code 2113			Į	10g. Ci	itizen of Wh		try?	F
36	er dea or itel miner	by	11. Marital Status  1  Never Marri 3  Widowed	ied 2 ☐ Marrie	12. Was Decedent Armed Forces at 1  Yes 2	Ever in U.S	1	Nas Decedent of F f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	an, Mexican	n, Puerto R	ify Yes or No- lican, etc.)		14. Race	- America White, e	etc.	
8	2 hours aft "natural", dical Exa	lete		15. Decedent			16a. Deced	dent's Usual Occur	oation			16b. k		of Business/Industry		
21215-0036	within 72 giene. er than "l , the Mec	Completed	Elementary/Seco	t grade completed)  College (1-4 or	5+)	life. D	kind of work done O NOT use retired) <b>LCAL ASSI</b>	)		g			ALTH	•		
Maryland	should be filed wit and Menta! Hygie is marked other aumatic event, tt	To Be	17. Father's Name (I	st) unk.		18. Mother's Name (First, Middle, N JULIA ASHBY						<del></del>				
Man	shoul h and h 7 is ma rraums	FRANCES RAY/DAUGHTER				19b. Mailing Address (Street and Number or Run 3724 BRICE RUN RD. AF					Route Numbe	er, City or	r Town, Sta	te, Zip C	ode)	
	l and 2 l Healt Item 2 other i					20b. Pl	3724 lace of Dispo	C. G RA					3			
<u>m</u>	Page 1 nent of ant: If i			☐ Cremation 3 5 ☐ Other (Sp	3 ☐ Removal from State ecify)	e ce	emetery, cren	/ <b>-2012</b>			Ť	y or Town, State				
Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ott		21. Signature of Fur	neral Service Lic	censee	1						MES A. MORTON & SONS F.I				
			23a. Par 1. Enter t	he disease, or c	complications that cause	ed the death							MD Z	1217	Approximate	
٥	Physician/ Medical		shock, or hear Immediate Cause (I disease or condition resulting in death)	Final	a. Due to (or as	Athe	Los Cl	evotic c	ardio	vasc	ulae	Dr.	Sease	_	Interval Betwe Onset and Dea	
	Examiner	_	Sequentially list cor	nditions.	b. —		-	I Diab	etes	me	leitus			years		
di	and transit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	nmediate rlying injury	c. Due to (or as			-								
760	ate be exe physician the burial	1	resulting in death) t	.dst	d	a consequi	——————————————————————————————————————									
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent in the past 12 r 1  Yes 2 p 9  Unknown	months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3	Ectopic pregnand Other (specify)	су	_			23d. Date Mont		ry Day Yea	ur
P.0	that the	절			s contributing to death		-	nderlying cause gi	iven in Part I	l.	23e. Did t	obacco ı	use contrib	ute to th	e cause of deat	th?
rds,	een sig een sig nould t	ed	Chi	ome K	idney dis	Rase					10	Yes 2	No 3	☐ Prob	ably 4 🗆 Un	known
eco	ne lawin e has b age 2 si	힐									24a. Was auto perfo		pri- de:	or to cor ath?	sy findings ava npletion of caus	ilable se of
ᆱ	lan: Th	န္တို	25. Was case referre	ed to medical		-		26. P	lace of Deat	th (Check	1 🗌 Yes only one)	2 X N	o 1 [	Yes	2 X No	
ΓĶ	hysic this ce al direc	To Be	1 ☐ Yes 2 🔀	Q No			ER/Outpatien		4 IXI NL		ne 5 🗌 Resi			(Specify)		
ou o	ending F eath. or: After the funer	ficate	27. Manner of Death  1 Natural  2 Accident	5 Pending Investiga	ation		28b. Time of injury	work			8d. Describe I	now injur	y occurred			
Division of Vital Records,	ital or Att irs after d al Directi lled in by	2   Accident   Investigation   3   Suicide   4   Homicide   4   Homicide   determined   28e. Place of Injury - A building, etc. (Spe					At home, farm, street, factory, office 28f. Locatio					8f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hosp within 24 hou To the Fune completely fi	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practitioner: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and only one)					owledge, death occurred at the time, date and place, and due to the ca tition and/or investigation, in my opinion, death occurred at the time, date a of my knowledge, death occurred at the time, date and place, and due to t					e, date and place, and due to the cause(s) and manner stated			er stated.	
	Tor with		29b. Signature and t	itle of certifier	Faliher	und		29c. Licens	e number 2158			29d. Da	te signed (	Month, E		
7					ho completed cause of	death (Item:			L. 1 . P	, ,	0 1	10	N 2 A	15	7.42	
	Stat	-	31. Date filed (Mont)	h, Day, Year)	kh my 5	rar's Signat	re T	1 0 P	TE 108	a	mnsul	10,0	(M) 2	-1-	8	
	Registra	r	ח	EC 1 3 7	1117 1/2	. 1	130	Per								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Walter C. Williams 2012 12:10 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Funeral 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 434-20-0783 1 X M 2 □ F 89 Dec. 28, 1922 Louisiana 10a State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 321 University Blvd. West #131 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Never Married 2X Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 Divorced 4 Divorced Specify: Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4 or 5+) <u>4yrs</u> Postal Clerk Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental f ဂ္ Edward B. Williams Mamie Boyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 Madine F. Williams/Wife 321 University Blvd. West #131, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Page 1 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/18/2012 Silver Spring, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. narmani 7474 Landover Road, Hyattsville, MD 20785 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of): Examiner Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physicien and the burial-transit death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as 1 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, Cerebrovascular Accident has been si le 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ۖ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physicien: The law in within 24 hours after death.

To the Funeral Director: After this certificate has the completely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 so. autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) ဂ္ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending X Natural Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number

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DHMH 17 Rev 06-2011

State Registrar

EC 1 3 2012 Z

Yodit Negusse

31. Date filed (Month, Day, Year)

ener B. park

32. Registrar's Signature

use

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D69288

1500 Forest Glen Road, Silver Spring, MD 20910

December 11, 2012

			For State Registrar	State of Maryla	and / Departm		th and M	ental Hygi		
	Physicia Medic	al_	1. Decedent's Name (First, Middle, L Ella Lillian	Sanders	Walker			2. Date of Death Month	Day Year	3. Time of Death
	Examir	er	4a. Facility Name (if not institution, gi	ve street and number)	4b. C	BALTIM			4c. County of Dear	th
	Funeral Director		2111-21-14162	Sex 7. Age (In yr	s. last birthday) If Ur Mont Yrs.			8. Date of Birth (Month, Day, )	(ear) 9. Bir (Co	thplace (State or Foreign nuntry)
	laryland ka-f show ified at	Director	10a. State 10b. County	10c.	City, Town or Location Baltimo	60			101	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the M 23a or 26 Ist be not		10e. Street and Number	w Road		Zip Code	29	10	Og. Citizen of What Co	I
9	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1  Never Married 2  Married		If Yes, s	cedent of Hispanic pecify Cuban, Mex		ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
21215-0036	2 hours at "natural" edical Exe	Completed	3 Widowed 4 Divorced  15. Decedent's (Specify only highest of		16a. Decedent's U	s 2 No Spe	•	, [1	Specify: B	
12121	d within 7 lygiene. ther than nt, the Me	امها	Elementary/Secondary (0-12)	College (1-4 or 5+)		work done during i use retiled) LCNEX			Baltino	ols
Maryland	uld be file   Mental 1-   narked of     natic evel	To B	17. Father's Name (First, Middle Last	nders		18. N	/ 1 /	(First, Middle, Ma	aiden Surlame)	et
e, Mai	and 2 short Health and Health and Her traum			neron/Son	1104 N	icklow	imber or Runtil	Balti	City or Town, State Lip MOVE, MI	) 21229
Baltimore,	t. Page 1 at the tof H tant: If ite jury or ot		20a. Method of Disposition  1		o. Place of Disposition ( cemetery, crematory)	ame of other place) Amoria	12/1	7/12 2	Oc. Location - City or Arbutus	Town, State
Ba	Depar Impor eny in	ļ.	21. Signature of Funeral Service Lice	· Treene	<sup>22.</sup> √2 5/5/		nove 1	vari f	ineral S	envices 229)
	hysician/	X .	23a. Part 1. Enter the disease, or cou shock, or heart-failure. List only Immediate Cause (Final disease or condition	one cause on each line.	eath. Do not enter the m				1	Approximate Interval Between Onset and Death 30 MINOTES
	Medical Examiner	_	resulting in death)  Sequentially list conditions.	Due to (or as a conse	equence of):					
4	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to or as a cons	7.5.X.2.					
	be e siciar buri	cal	resulting in death) Last	Due to (or as a conse	equence orj:					
. Box 6876(	Inospinal or Autending Prysician: The law requires that the death certificate by A hours after death.  Funeral Director: After this certificate has been signed by the attending physistely filled in by the funeral director, page 2 should be detached for use as the to the total control of the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3   Ector	ic pregnancy (specify)			23d. Date of del Month	livery Day Year
s, P.O	requires that the des been signed by the s should be detached	d by PI	Part II. Other significant conditions	contributing to death but not			Part I.		acco use contribute to	the cause of death?
FLLA Records, P.O. Box	e law requ s has beer ige 2 shou	Completed by		BETES				24a. Was an autopsy performe	prior to o	topsy findings available completion of cause of
ta/下	cian: In certificate ector, pa	Be	25. Was case referred to medical examiner?	Hospital:			Death (Check o	1 ☐ Yes 2	No 1 ☐ Yes	3 2 No
of Vi	g rnysi erthis c neraldir	و: <u>1</u>	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatient 3   28b. Time of	28c. Injury at		e 5 Residen	ce 6 Other (Spec	ify)
WALKE Division of	Attendin er death. ector: Aft by the fur	rtifical	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not determined	be 28e. Place of Injury - At	home, farm, street, fact	work? 1 Yes 2		3f. Location (Stre	et and Number or Rui	ral Route Number,
S.≧.	io orne hospital or Auranding Prysician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certificate:	29a. Certifier 1 Certifying Ph	vsician: To the best of my kno	owledge, death occurre	d at the time, date	and place, and	City or Town,	State)	ated
(P)	o tne Hi ithin 24 o the Fu omplete		(Check 2 ⊔ Medical Exam	niner: On the basis of examinating	tion and/or investigation,	in my opinion, deat counted at the time	th occurred at the	e time, date and	place, and due to the distance (s) and marker a	cause(s) and manner stated.
	->=0		· all	Cat 1	ins	D005	1863	5 2	d. Date signed (Month)	R 10, 2012
	X		30. Name and address of person who	completed cause of death (It	em 23a) (Type, Print)	ST A	GNZ	s HUS	E BA	2 10, 2012 27 mare
	Stat Registra	e ir	31. Date filed (Month, Day, Year) OEC 1 3 2012	32. Registry Sig	fall					

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State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr e934 12-13-12 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Northwest Hospital Randallstown Baltimore Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth **Funeral** 1 ₹ M 2 □ F Months 3<del>-30-</del>1925 Days 87 **Director** 218-18-9718 MD Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Baltimore Randallstown 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9223 Turnbull Road 21133 USA permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. "Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. The Madical Factor 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. SpecifyAfrican-American 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Baltimore County Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jessie Williams Evelyn Parr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa L. Williams/Wife 9223 Turnbull Road, Randallstown, M) 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 12-15-2012 Baltimore, MD 4 Donation 9 Other (Specify) of Fure al Service License 22. Name and Address of Facility Vice Funeral Rome P.A. of Ralto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one each line. Onset and Death Immediate Cause (Final Physician/ Theroscienotis ardiovacuker disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to in medicause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a ounsequence off Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha irector, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury hours after death. neral Director: Aft d filled in by the fur 1 Yes 2 No ☐ Accident ☐ Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Wilmer Dr. Suite 220 Horsham, Pa. 19044 Kevin-Sean Anthony McGann 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Beth Y. Wilcove 4:13 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens - Riderwood Silver Spring Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours Director 078-24-0902 1 🗆 M 2 💢 F 88 Yrs. 09/23/1924 New York is then "neturel", or items 23e or 28e-f eho 10a. State 10b. County filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maruland Silver Spring 1 ☐ Yes 2 X No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3158 Gracefield Road, #FC423 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. 1 ☐ Yes 2 📈 No If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X☐ No Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit. Depertment of Health and Mental Hygler Importent: If Item 27 is marked other theny in njury or other treumetic event, the once. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Yellen Sulvia Stiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6710 Old Stage Road, Rockville, Maryland 20852 Michael Wilcove - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 12/13/2012 Clarksburg, Maryland 4 Denation 5 Other (Specify) 21. Signature of Funeral Ser 22. Name and Address of Facility Hines-Rinalli Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 23a. Part 1. Enter the Approximate Interval Between Onset and Death 2 Years Immediate Cause (Fina Physician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): inding physicien end use as the burlai-trensit Cause (Disease or injury that initiated events or Attending Physicien: The lew requires thet the death certificete be executed resulting in death) Last Due to (or as a consequence of): signed by the ettending physicien d be detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ Completed Anemia of Chronic Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hupertension has performed? 1 ☐ Yes 2 🔯 No within 24 hours after death.

To the Funerel Director: After this certificate to completely filled in by the funeral director, peg 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) 1 ☐ Yes 2 🛣 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 X Natural Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) CRNP, 3110 Gracefield Road, Silver Spring, Maryland 20904 Eileen Gemmell. 31. Date filed (Month, Day, Year)

DFC 1 3 2012 32. Registrar's State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 40368 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary S. Wegner December 10:30am 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 353-32-3823 1 🗆 M 2 💢 F 02/27/1941 Illinois 27 is merked other then "netural", or items 23a or 28a-f shov traumatic event, the Wedical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Wheaton 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12205 Bond Street 20902 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 ☑ Yes 2 ☐ No 1959—
If Yes, Give Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: Completed 1960 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) U.S. Nuclear Elementary/Secondary (0-12) College (1-4 or 5+) Reactor Systems Engineer Regulatory Commission 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be file of Health and Mental F I item 27 is merked of 2 Clarence F. Wehlage Mabel Collie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Shady Spring Place, Gaithersburg, Maryland 20877 permit, Page 1 end 2 Department of Health Important: If item 27 any injury or other ti Kathleen Dodd - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Dpnation 5 ☐ Other (Specify) Lincoln Crematory 12/13/2012 Brentwood, Maryland Ft. e of un of Service Lice 21. Sigratu 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage Renal Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after deeth.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the Intered infector, page 2 should be detached for use as the bunkal-transit Cause (Disease or inju. y that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? ☐ Yes 2 🗓 No death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 X No 1 V Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Layanti 12/5/12 0052586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 M.D., Jayanti Lalbhai Patel, 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Amend #27, per MD g934 state of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carol Denise Williams November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Cecil Union Hospital Elkton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** AM Days Hours (Month, Day, Year) OV. 2, 1969 1 □ M 2 ⋤ F 217-84-8991 43 Maryland **Director** Usual Residence of Decedent 28a-f shov 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified 1 🗌 Yes 2🗶 No Elkton Maryland | Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21921 55 Hollingsworth Manor 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Yes 2X No by 1 Never Married 2 Married CHROL DENISE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Store Clerk 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Betty Carol Bottom Jacob Rodney Slicer ROL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Department of Health a Important: If item 27 is any injury or other trauonce. 55 Hollingsworth Manor, Elkton, Maryland 21921 Terry Williams / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdn: 11-20-2012 Aberdeen, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. essecu dillauri 1317 Cokesbury Road, Abingdon, MD 21009 rar/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, seck, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final PNEUMONIA Physician/ HOURS disease or condition Medical resulting in death) Examiner HOUSRS MYOCARDI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 27 Division o 1 X Natural work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of MD 18/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ElKton, MA Baw St. MD 106 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vincent Adamovich Medical oven 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cester NURS ma om. **Funeral** Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 064-24-8234 **Director** 1 🛛 M 2 🗆 F 12/21/1930 New York 28a-f shov 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits rector Maryland Wicomico Salisbury 1 Yes 2 X No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8068 N. West Road 21801 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give AirForce Black, White, etc. δ 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: 3 Divorced 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Repairman Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked of ၉ Adam Adamovich Josephine Corona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8068 N. West Rd., Salisbury, MD 21801 Diane Adamovich/Spouse 1 and 2 s f Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 a
Department of H
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Salisbury Crematory 11/28/2012 4 Donation 5 Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause breach line. Approximate Interval Between Observand Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence on sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death, Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) Month Dav ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 Khinknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perfor death? 2 🗆 No 1 Yes To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; I 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) မ 1 Tes 2 ANO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗌 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Countrying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signaty 29d. Date signed (Month. ompleted cause of death (Item 23a) (Type, Print) IVA 31. Date filed (Mo. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20<sup>Year</sup> 11:50A M Kevin James Augustine Nov Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gaithersburg Montgomery 20017 Mattingly Terrace Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Day, Year) Director 187-50-4741 53 Pennsylvania Usual Residence of Decedent or 28a-f show notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

The strain and Mental Hygiene with a strain or items 23a or 28a-f sho often traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg MD Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 20879 USA 20017 Mattingly Terrace 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 X Married 2 X No Yes Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Gertrude Melissa Nealen Edward Rudolph Augustine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20017 Mattingly Terrace, Gaithersburg, MD 20879 Connie Augustine (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 permit. Page 1
Department of I
Important: If its
any injury or of ₹ 1 Durial 2 X Cremation 3 X Removal from State 11/17/2012 Altoona, PA 4 Donation 5 Other (Specify) Cremati Service Name and Address of Facility 22. Name and Address or Facility
Thibadeau Mortuary Service, P.A.
7 Park Ave., Gaithersburg, MD 20877 M00956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition Multiple Myeloma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Month Pregnant at time of death 9 Unknown signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N wrthin 24 hours after death.

To the Funeral Director: After this certificate the Completed filled in by the funeral director. 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes Other: 2 X No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Prantitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42452 11/15/2012

State Registrar 31. Date filed (Mor

DHMH 17 Rev 7/2009

18111 Prince Phillip Dr., #327, Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chitra Rajagopa1/,

MD

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla		artment of F		Mental Hy	20	112	40372
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Victor Hugo Alba		tmodito of E	- Journ	2. Date of De	Reg. No. <u>2</u> eath 18, 201		3. Time of Death 11:30 pm
	Medic Examin		4a. Facility Name (if not institution, give street and number) 12921 Poppy Seed Court		4b. City, Town, or Germa	Location of Dea		4c. Coun	ty of Death	·
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birthp Count	lace (State or Foreign
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	e Mar r 28a- notifie	Direc	MD Montgomery  10e. Street and Number	German	10f. Zip Code			40. 0%	1145-1-4	1 ☐ Yes 2 ☐XNo
	vith th	rall	12921 Poppy Seed Court		2087	74		10g. Citizen of	ombia	
	er mu	un-	11. Marital Status 12. Was Decedent Ever in U	U.S. 13.\	Was Decedent of Hi f Yes, specify Cuba		Specify Yes or No		ce - America	
036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		if Yes, specify Cuba 1 X Yes 2 □ No				ack, White, e y: Whi	1
Baltimore, Maryland 21215-0036	72 hour	mplet	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupa kind of work done d O NOT use retired)		orking	16b. Kind of	Business Ind	lustry
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and	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) Luis Angel Alban				ame <i>(First, Middl</i> e Lilia Z		ne)	
ary	hould and Mar is mar		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a				State, Zip C	ode)
Σ «	1 and 2 s of Health item 27 i		Elena Beatriz Arias/wife			Seed	Court			Md 20874
Jore	Page 1 a nent of H ant: If ite ury or oth		1 X Burial 2 Cremation 3 Removal from State	o. Place of Dispo cemetery, cren	sition (Name of natory or other plac u1 's Cen		Date	20c. Location	-	
altın	permit. Page 1 a Department of I Important: If it any injury or of		4 ☐ Donation 5 ☐ Other (Speciff)  21. Signature //-uneral Service Livens e		Harrer Adres		24/201.			wn,Md
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-4	hydician/		23a. Part 1. Enter to disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Live: C		er the mode of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)  a. L1V3 C  Due to (or as a conse							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	equence of):						
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289	ertifica ding ph se as tl	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg	inancy				224 5	ate of delive	
. Box 68/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours attended.  within £4 hours attended att.  To the Funeral Director After this certificate has been signed by the attending physician and To the Funeral Director, page 2 should be detached for use as the burial transitions.	Physician/Me	Sol. was decedent pregnant     Live Birth 2	etal death 3	Ectopic pregnanc Other (specify)	У				Day Year
л О	s that the gned by the detail	by	Part II. Other significant conditions contributing to death but not r	esulting in the u	underlying cause giv	en in Part I.				e cause of death?
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DIVISION	l or Atte after des Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rural	Route Number,
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	To the within To the Comple	Σ	only one) 3 L Certifying Nurse Practioner: To the best of 29b. Signature and title of certifier	my knowleage, (	29c. License		nace, and ode to t	29d. Date sign		
	3		> Steen Tiller	mp	D	006319	5	гои	7.21,	2012
			30. Name and address of person who completed cause of death (Ite							
	Stat	e	31 Date filed (Month Day Year)   Registrar's Sign	Piccar	d Drive	Rockv:	ılle,Md	20850		
	Registra		31. Date filed (Month, Day, Year)  NOV 2 2012	2. Apar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Jayden рм Medical Akateh 2012 November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) None **Director** 1 2 M 2 □ F Nov. 9, 2012 Usual Residence of Decedent i Hygiene. i other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11434 Lockwood Drive, Apt. 102 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) None Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Elvis Epah Rose Fualem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elvis Epah/Father 11434 Lockwood Drive, Apt. 102, Silver Spring, MD 20904 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cemetery 1 Burial 2 Cremation 3 Removal from State 24, Department of Important: If any injury or Nov. 4 ☐ Donation 5 ☐ Other (Specify) 2012 Silver Spring, MD 21. Signature of uneral Service Lensee 22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd. W, Si Home Inc 1ver Spri Tates Michael MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Persistent Pulmonary Hypertension of Newborn Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trapsit ed by the attending physician and detached for use as the burial-transit Congential Fungal Infection that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 Extreme Prematurity IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural
2 🗌 Accident
3 🔲 Suicide
4 📗 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in multiplication in multiplication in multiplication. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License numbe D62206 November 21, 2012

Registrar

1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Jessica McAdoo, MD

NOV 26

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Nov. Allwine 19 10:59 AM Yorkoff Lee Sonia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis . Social Security Numbe 9. Birthplace (State or Foreign Country) Virginia 6. Sex 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Ye March 16 1 M 2 😿 Days Hours Min 578-56-4011 72 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Edgewater Anne Arundel 1 Yes 2 TNo Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 8 Lee Airpark Drive Apt. 322 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3**X**Widowed 4 ☐ Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lambert Ama Frederick Yorkoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7785 C. Street, Chesapeake Beach, MD 20732 19a. Informant's Name/Relationship (Type, Print) Kym Mack - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 21, Clinton, Maryland Lee Crematory 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 20736 Jennifer Lane, Owings, MD GoE 8200 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician Due to (or as consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Too both area a consequence off cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 performe within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2  $\square$  No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) the funeral Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation Accident 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29c. License numbe D0056324

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day,

dew 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAMC

Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0455 M JUDITH ANN ALDRIDGE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Western MD Regional Medical Center Cumber land Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. Days Hours 233-58-3350 Director 1 □ M 2 💢 F 74 03/12/1938 Maryland Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD 1 ☐ Yes 2 X No Allegany Cresaptown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 14704 Main Street 21502 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 M Married þ 72 hours after Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: than "natural", If Yes Give White 3 Widowed 4 Divorced Completed Year or Dates. Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Bond Louise Irene Twigg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau John S. Aldridge, Sr./Husband 14704 Main Street, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1  $\overline{\mathbf{x}}$  Burial 2  $\square$  Cremation, 3  $\square$  Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) M.S.V.C. Rocky Gap 11/29/2012 Flintstone, MD 22. Name and Address of Facility Upchurch Funeral Home, 202 Greene Street, Cumberland, MD Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Promoters/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Die to (or as a nonsequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months Year Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed this certificate has 2 No 25. Was case referred to medical examiner?

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I Director: After this ed in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Delatural work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a Funeral D Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 **To the (** Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

Cumber 2nd,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

MID

NOVEMBER 26,2072

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ai er	4a. Facility Name (If not institution, g				4b. City, Tow	n, or Location		Overibe1		. County of			
	Alice Byrd Tawe	s Nursing	Home		Cr	isfiel				So	mer	set	
	,	5. Sex 7. 1 □ M 2 🛣 F	. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Ye Months Da		er 24 Hrs. Min.	8. Date of Birt (Month, Day	th y, Year)	)	9. Birth Cou	place (State or Forei ntry)	
	216–14–9366 Usual Residence of Decedent	12	88	115.				Sept. 1	15,1	924 M	ary	land	
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Funeral Director	4 Hudson Street	1				2181	_			US		and Indian	
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Be	Thomas Edward Pa	*			18. Mother's Name (First, Middle, Marie How					•			
2	19a. Informant's Name/Relationship		19b. Mailir	Iling Address (Street and Number or Rural Route Numb						tate, Zi	p Code)		
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	20a. Method of Disposition	ПВ	re	ace of Dispo emetery, crer	sition (Name o	f place)	С	ate	20c. L	ocation - C	ity or T	own, State	
	1 Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	e Mem. Park 11/25/2012 Crisfield, Maryland											
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21. Signature of Funeral Service Licensee 22. Name and Address of Mary Beth Bradshaw-Pruitt 306 W. Main													
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>D</sup>2012 Physician/ Nov. Ackermann 8:58 P M Ruby L. 19. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital 4th floor If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 091- 20 - 0613 1 - M 2 7 F Feb. 14, 1925 Virginia 87 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Chesapeake Beach 1XX Yes 2 ☐ No Maryland Calvert 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 20732 U.S.A. 3336 Silverton Lane permit. Page 1 and 2 should be filed within 72 hours after death \( \) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Fysurian once. Was Deceus.
Armed Forces?
Yes 2 XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 ☐ Widowed 4 🏵 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Buyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Netie Authur Τ. Monday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20689 5050 Barrington Lane, Sunderland, MD Robert Ackermann- Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee Crematory 20a. Method of Disposition Nov. 2012 20c. Location - City or Town, State ☐ Burial 2 XI Cremation 3 ☐ Removal from State Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury cons, quence of): or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 after death.

Director: After this certificate has been signed by the attending the transmittened for use it. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Year Pregnant at time of death 9 Unknow death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ၉ 1 Yes 2 Other: 1  $\square$  Inpatient 2  $\square$ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature

DHMH 17 Rev 06-2011

State Registrar

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death (Item 23a) (T

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Edna I. Bruce November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min. (Month, Day, Year) Director 579-40-3054 1 □ M 2 🔀 F Usual Residence of Decedent 83 Nov. 4. DC or than "natural", or Items 23a or 28e-f show the Medical Evaminer must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's 1 1 Yes 2 □ No Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 12807 Peachleaf Court 20774 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Never Married 2 Married Black, White, etc. δ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced Black Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 halth and Mental Hygiene. 27 Is marked other than "n r traumatic event, the Media (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Sterilization Technician Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Day Samuel Bruce t. Page 1 and 2 should by rtment of Health and Mer rtant: If Item 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Brooks - Daughter 12807 Peachleaf Court Upper Marlboro, Md. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 Department of I Important: If It any injury or of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2012 Cedar Hill Cemetery Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 Benning Road NE Washington, DC <u>4001</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition ata Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (crasia nonsequence or; the Hospital or Attending Physicien: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burlei-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 4 Pregnant Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) မ Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical

State

29a. Certifier

only one

Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year)

2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			, ror	artment of Health and Mer	•	2012 40379
	Physici	an	1. Decedent's Name (First, Middle, Last) Roy Brady			ay Year 2 2012 01:5 M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	10V 2	c. County of Death
н	Examili	lei	Bon Secours Hospital	Baltimore	1	30 Homore Cety
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 237 &6 1179 1974 2 F 61 Yrs.	Months Davs Hours Min.	Date of Birth (Month, Day, Yea )6/27/1	9. Birthplace (State or Foreign Country) 951 North Carolin
	iand ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation	· ·	10d. Inside City Limits
	Mary a-f sh	ţō	MD Prince George For	cestville		1 ☐ Yes XXNo
	th the	lrec	10e. Street and Number	10f. Zip Code	_	Citizen of What Country?
	ath w	lal	6577 Pennsylvania Ave	20745		.S.A.
920	urs after de al', or Itams	by Fune	11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  XXYes 2 No If Yes, Give Year or Dates 1971  Army	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric  1 ☐ Yes 2 ☑ No Specify:	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.  Segrificack
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 21a profiled at event, the Medical Exerting that must be recified at	Completed by Funeral Director	15 Decedent's Education T   169 Dece	ident's Usual Occupation is kind of work done during most of working DO NOT use retired) mputer Operator		Kind of Business/Industry
land 2	ed a b	To Be Co	17. Father's Name (First, Middle, Last)  Willie Hicks	18. Mother's Name (F LOUISE	irst, Middle, Maide	en Surname)
	nd 2 state at trau		19a. Informant's Name/Relationship (Type, Print) Adrianne Brady (Wife) 19b. Mail	ing Address (Street and Number or Rural R 7 Pennsylvania Av	e Fore	stville Md
Baltimore,	Page nent o ant: If ary or	. 13	20a. Method of Disposition XIXBurial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify)  20b. Place of Disposition Commettery, cre	osition (Name of matory or other place) Cemetery Dec 4,		Location - City or Town, State harlotte N.C.
Balt	permit. Departrimporta		Koger & Mason 9	2 Name and Relegself acity Maso 08 Kennedy St NW	Wash D	ral Service C 20011
			23a. Part1. Enter the disea of or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death
П	Physician / /Medical			pneumonitis		
П	Examiner		Due to (or as a consequence of):	ion Preumo	n.h.	
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	LVII TI COUNTO	1110	
	cuted nd ransit	Examlner	that initiated events	eral diseas	l	
760,	te be executed ysician and ie burial-transit		resulting in death) Last  Due to (or as a consequence of):	D11-8 = d11100	10	
6876	cate b	dlcal	d. Chastage	Lucy austa	ve	
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	res that igned b be deta	by Pł	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
of Vital Records,	w require been sig should b	ed b	HIV positive State	us	1 🗆 Yes	2 No 3 Probably 4 □Unknown
eco	e law re has bed je 2 sho	Completed	Insulin defendent de	abeter	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
= =		Con	Hypertension		performed? 1 ☐ Yes 2001	death? No 1 Yes 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (C		
of	Physic this raldii	.: To	1 ☐ Yes 2 ☐ No	fit 3 DOA 4 Not sing Home	5 Residence  1. Describe how in	6 ☐ Other (Specify) jury occurred
lon	Attending F ir death. actor: After by the funera	atlor	Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	al or Attendia s after death. sl Diractor: A ed in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	Hospit 24 hour Funara stely fille	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.		at the time, date a	and place, and due to the cause(s)
	within 2 To tha complet	Σ	29b. Signature and title of certifier  Wy Columbia  30. Name and address of person who completed cause of death (Item 23a) (Type M69es Gebremarian 4666)  31. Date filed (Month Day Year) 22 Pagistrar's Signature	D 18327		Date signed (Month, Day, Year)  V 22 2012
	2W		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) AVI Kens Ave	Ra It	n Md 21229
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	2)	124 11	
DH	MH 17 Rev 1/2		- O have	-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For	State of Ma	ryland /	Depa	ırtmen	nt of H	leaith a	and M	lental Hy	giene				
			1 - State Registrar			Cer	tificate	e of D	eath			Reg. No.2	012	)	403	80
	Physicia	n/	Decedent's Name (First, Middle, Last	,							2. Date of Dea Month NOV	ath Day	Year		3. Time of D	
gald.	Medic Examin	al	JOHN P. B.  4a. Facility Name (if not institution, give:	ARRETT street and number)			4h City	Town or	Location o	of Doath	NOV		20 <sup>Year</sup>		09:0	9 м
	Examin	er	WASHINGTON AD	,			4b. City,		CAKON		ARK		ounty of Dea		v	
11,000	Funeral		Social Security Number 6. Se		(In yrs. last bir	thday)	If Under		If Under 2		8. Date of Birt	h	9. Bi	irthplac	ce (State or I	Coreign
H	Director		578 36 1098 11 Usual Residence of Decedent	<b>⊠</b> M 2 □ F	83	Yrs.	WOITINS	Days	nours		(Month, Day MAY 17		<u> </u>	ountry) TRG	INIA	
	and ahow	or	10a. State 10b. County		10c. City, Tow	n or Loc	ation							_	. Inside City	Limits
	Maryla 28a-f	Director	MD PG		CAPIT	OL	HEI	GHTS							1 🕅 Yes 2	2 □ No
	a or 2		10e. Street and Number				10f. Zip					-	n of What C	ountry	?	
	within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-f ahow the Medical Evaniher must be notified at	Funeral	1207 ADDISON						743	1.0.00			USA			
<b>(</b> 0	or Itel	by Fu	11. Marital Status 1 ☐ Never Married 2 🕅 Married	12. Was Decedent Ev Armed Forces? 12 Yes 2 1 N	/e1119/46 to	13. W	Yes, spec	lent of His cify Cubar	spanic Orig n, <b>Me</b> xican,	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	14.	Race - Am Black, Whi			
903	rs after	ed b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1947	1	☐ Yes	2 🔼 No	Specify:			Sp	ecity: $\mathrm{BL} I$	ACK		
5-0	2 hou	Completed	15. Decedent's Ed (Specify only highest gra	. Deced	ent's Usua ind of wo	al Occupa rk done di	ition uring most	of worki	ng	16b. Kind of Business/Industry				-		
121	within 72 giene. ier than "	Com	Elementary/Secondary (0-12)		e kind of work done during most of working DO NOT use retired) ALCOHOL & G ABUSE COUNSELOR					Ρļ	PRIVATE					
<b>d</b> 2	led w I Hygi other	a	17. Father's Name (First, Middle, Last)													
Maryland 21215-0036	1 and 2 should ba filed w of Haalth and Mental Hyg Item 27 ia marked othe other traumatic event,	ျ	ISAIAH BARRE	TT		18. Mother's Name (First, Middle, Maiden Surname)  EMMA JONES										
<b>la</b> n	shoul		19a. Informant's Name/Relationship (Ty)		FE 19	b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numbe	, City or Tou	wn, State, Z	200	<sup>#</sup> 43	:
e,	and 2 Haalth em 27 ther tr		BARBARA L. COLL: 20a. Method of Disposition	INS BARRI					I RP		TH #4					TS
Baltimore,	8 ± 5		1 Burial 2 ☐ Cremation 3 ☐			ery, crem	atory or o	ther place			Date 20/12		tion - City o TENH.			
랿	permit. Page Dapartmant o Importent: If any injury or pnce.		4 ☐ Donation 5 ☐ Other (Specify 21. Sign ture 1 1 neral Service License		CHELT	-					30/12	СПЕЦ	I ENT.	An	עויו	
Ä	permit. Dapartr Importe any inju	9 2	) (L) Dua	7.CC	0527		Name and Address of Facility ATSON FH 3435 14th ST NW W					WASH	SH DC 20010			
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the cause on each line.	the death. Do	not ente	r the mod	e of dying	, such as c	cardiac o	r respiratory an	est,	•		oproximate terval Betwe	en
f	hysician/ Medical	8 4	Immediate Cause (Final disease or condition resulting in death)	Carylon	Miscu	las	A	cid	ent.						nset and De	
تميدا	Examiner		resulting in death)	Due to (or as a	consequence	of):	dam	linie	202.1	100	Man	120				
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):	Jaro	rdioiaseuler Dismise						$\vdash$		
	outed nd transit	kam	cause. Enter Underlying Cause (Disease or injury that initiated events	Diabute	25 Mg	olli	Fus	Ore	nd ,	Hyp	40 Tonsa	on				27
	sate be executed physician and the burlai-transit	dicai Examiner	resulting in death) Last	Due to (or as a	consequence	of):				//						
760	cate by physics the is	edic		d												
89	certifi anding use a	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy	ь оП	C-+					230	d. Date of de	elivery		
Box 687	death na atte ed for	sicie	1 Yes 2 No	4 Pregnant at	time of death		Ectopic p Other (sp		<i>'</i>				Month	Da	ry Yea	ar
P.0.	requires that tha death certific bean signed by tha attanding p should be datached for use as	Completed by Physician/Me	9 ☐ Unknown  Part II. Other significant conditions co		t not resulting	in the ur	nderlying (	cause give	en in Part I		220 Did to	phaceo uso	contribute t	o tho c	ause of dea	th2
S,	signe d be d	d b	End stag	g Round	Disa	23/27	,g	<b>J</b>					101	_	aly 4 ☐ Ur	
ord	requ bean shoul	lete	Panpharal (	macilla	- DX	7002 V	4				24a. Was	an 2	24b. Were a	utopsy	findings ava	ailable
Sec	he lav te has age 2	m o	Fready	aln matter	2 Drot	PV	مران	SI	NOKK	-	autop perfo	rmed?	prior to death?	comp	letion of cau	
<u>a</u>	lan: T rtifica ctor, p	BeC	25. Was case referred to mediant examiner?	acpart)	4031		101		ce of Deatl		1 \(\sum \) Yes only one)	2 No	1 ∐ Ye	×s 21	_1 NO	
5	hysic his ce	မ	1 ☐ Yes 2 Ø No		nt 2 🗆 ER/O		3 □ D0	Othe	r: 4 🗌 Nu	rsing Ho	me 5 🗌 Resid	ence 6 🗆	Other (Spe	cify)		
ם כ	ding P	ate	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	Year) 28b.	Time of injury	- 1	8c. Injury work?	?		28d. Describe h	ow injury oc	curred			
Sio.	Attend death ctor: by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		v - At home, fa	arm. stre	M et. factory		Yes 2 🗌	-	28f. Location (S	treet and N	umber or R	ural Ro	ute Number	-
Division of Vital Records,	s after	ဦ	4 ☐ Homicide determined	building, etc.			,,	,		Į.	City or Tow		arribor or th	arai i io	ote (Valliber	
	To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use as the burial-transf	Medical	29a. Certifier 1 Certifying Physical Check 2 Medical Examin	ner: On the basis of exa	amination and/	or investi	gation, in r	my opinior	n, death occ	curred at	the time, date a	nd place, an	d due to the	cause	(s) and mann	er stated.
	orthe vithin orthe	ž	only one) 3 Certifying Nurse 29b. Signature and hitle of certifier	e Practitioner: To the	best of my kno	wledge,	death occ	urred at th	e time, date	e and pla	ce, and due to t	ne cause(s) a	and manner	as state	ed.	
	0		D # 1	10				4	786	7		11/2	26/1	Z.	,	
	P. D.W.		30. Name and address of person who co	ompleted cause of dea	ath (Item 23a)	(Type, Pr	int)		2.	_ # 2	io, Has	Dien	) ("			
_			Unity Zunisa 31. Date filed (Month, Day, Year)	470/ £01/	rdelph	Pa	#2	16,1	WK	1111	D, MAS	COS	16			
	Stat Registra		NOV 2 8 201	2 Jenne	s signature	par	es!									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c per fh g936 2-25-13 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 4038 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 24, 2012 21:52 Veronica I. Butler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 66 Director 579-68-0971 1 🗆 M 2 🔼 F 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, <u>the Medical Examiner must be notified at</u> **Funeral Director** Upper Marlboro 1 X Yes 2 No Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 11706 Cheviot Court 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married and 2 should be filed within 72 hours after thealth and Mental Hygiene. ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give African 3 🖾 Widowed 4 🗋 Divorced Year or Dates Ámerican 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Driver Metro Private 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Juanita Diggs Veron Whiteing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20768 Greenbelt, Maryland Kevin Butler - Son P O Box 1142 sortant: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 a
Department of H
Important: If ite
any Injury or ot 20c. Location - City or Town, State cemetery, crematory or other place, Lee s Crematory 1 Burial 2 Cremation 3 Removal from State Dec. Clinton 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John T. Sterry 1 20019 Washington, DC M00560 4001 Benning Road NE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (University of the Cause (Univer Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 morths?
1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year certificate has been signed by the irector, page 2 should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CON TRAUGO DIABETE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an PERIPHER performed 1 ☐ Yes 2 ☐ No 2 🖳 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 Natural 2 Accident 1 🗌 Yes 2 🗌 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Funeral Directive filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) ð 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier DO 6905 YOUEMBER 27 2012 1501 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMpou BERNICE KUREON BUENUE TAKOMA PARIK, 000 7,600 MD 20912 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eugene S. Bryant November 2012 10:38 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/05/1941 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Fairmount Hgts Maryland Director 1 🙀 M 2 🗆 F <u>213-40-7169</u> 71 28a-f shov Hygiene. other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Prince George's Temple Hills 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3103 Goodhope Avenue # 605 20748 U.S.A. 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 😾 Married δ 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Hotels & (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ilth and Mental Hygien 27 is marked other the r traumatic event, the 11th Maintenance Engineer Apartment Complexes Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ þe Sylvester J. Bryant Marjorie C. Sellman 1 and 2 should b of Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara O. Bryant/Wife 3103 Goodhope Ave.#605, Temple Hills, Md. 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 6 1 KBurial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) Harmony Mem. Park 12/01/12 Landover, Maryland iny in 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D aug CC0316 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ ta disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s after death.

Director: After this certificate has autopsy 1 Yes 2 No Yes 2 No filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 🗆 No Other: Certificate: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier з 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number

State Registrar

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DHMH 17 Rev 06-2011

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Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Reginald Sebastian Bowen Month Day 3:00 P M Medical 11/ 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Prince Georges 4b. City, Town, or Location of Death Prince Georges Hospital Center Cheverly, MD. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 5. Social Security Number 217-92-7370 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 48 **Director** 1 XM 2 TF 11/4/1964 DC ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Prince Georges Landover 1x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
USA 3110 82nd Ave. 20785 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Carpentry Self Employed Be 17. Father's Name (First, Middle, Last) Norbert Donald 18. Mother's Name (First, Middle, Maiden Surname) Bowen Betsy Bell-Bowen 19a. Informant's Name/Relationship (Type, Print)
Dawn Michelle Johnson/sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \$\t^4 806 69th Pl. Landover, MD. 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State Riverdale Park 11/29/12 any injury o Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Washington DC 20019 22. Name and Address of Facility Dunn & Sons-5635 Eads St. MD138 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ lar disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Dertension that initiated events resulting in death) Last Due (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a Pregnant at time of death 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 🔏 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and litle of certifier 29d. Date signed (Month, Day, Year) 12M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature

Registrar

	-	101	partment of Health and I ertificate of Death	Mental Hygie	•								
Physicia: Medic	al .	Decedent's Name (First, Middle, Last)  Mary Haules Blanton		2. Date of Death	Day 2012 7:45 P M								
Examin	er	4a. Facility Name (If not institution, give street and number)  Woodside Center	4b. City, Town, or Location of Death Silver Spring		4c. County of Death  Montgomery								
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)								
		Usual Residence of Decedent  102  102  Yrs  102  Yrs  102. City, Town or		April 10,	, 1910 Virginia								
28a-f sh stified a	Director	DC	Washingt	on	1 🕱 Yes 2 □ No								
23a or 2	ralD	10e. Street and Number 1130 45th Place SE	10f. Zip Code 20019	100	g. Citizen of What Country? United States								
Department of Health and Mental Hygiene. Important: fritem 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 □ Yes 2 □ Yes 2 □ Yes 2 □ Yes 3 □	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto  1  Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: African								
an "natura Medical Ey	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	king 16	American b. Kind of Business/Industry								
Hygiene other th ont, the	as l	8th  17. Father's Name (First, Middle, Last)	Caterer 18 Mother's Nan	ne (First, Middle, Mai	Self-Employed								
Mental arked c	P	George Jones		da Willis	our duriency								
ulth and 27 is m r traum			ailing Address <i>(Street and Number or Rui</i> 854 <b>Critton Circle</b>										
If item or othe		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State	c. Location - City or Town, State										
partmer portant y injury ce,		21. Signature of Funeral Service Licensee			Laurel, Maryland neral Home, Inc.								
20 E # 8		Stevent M00560	4001 Benning Road		ington, DC 20019								
nysician/ Medical Examiner		23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Atrial Fibrillation  Due to (or as a consequence of):											
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Anemia  Due to (or as a consequence of):  Advanced Age —											
ohysician an the burial-tr	g	resulting in death) Last  Due to (or as a consequence of):  Hypertension &											
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year								
in signed by uld be deta	<u>چ</u>	Part II. Other significant conditions contributing to death but not resulting in the	2 🕱 No 3 ☐ Probably 4 ☐ Unknown										
cate has bee	Completed	25. Was case referred to medical	24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2  No										
is certific director	te 6 Other (Specify)												
h. After thi funeral	ate: To	27. Manner of Death 1   X Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) injur	e of 28c. Injury at	28d. Describe how									
's after deat al Director: ed in by the	Signature of Suicide and Suicide and Homicide steermined steermine												
ithin 24 hou.  the Funer: smpletely fill	29a. Certifier  (Check only one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)												
		Hemoll Johnym	29c. License number R 11683	20	Date signed (Month, Day, Year)  November 29, 2012								
Z M		30. Name and address of person who completed cause of peath (Item 23a) (Typ Lemoll Johny, CRNP 15245 Shady Gro											
Stat Registra	-	31. Date filed (M101) 3 earl 2012 Begistrar's Signature	all	,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1525 P M Alfred Norwood Bivens Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death TENINSULA ROGIONAL Center HICOMICS MEDICAL 596150414 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth Days (Month, Day, Year) 217-03-7748 Director 1**X**) M 2 □ F 3-12-1920 MD 92 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Worcester Pocomoke 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 706 Clarke Avenue 21851 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 1 Never Married 2X Married <u>م</u> Maryland 21215-0036 1 ☐ Yes 2 X No Specify. SpecifyBlack Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of MD Elementary/Secondary (0-12) College (1-4 or 5+) SSU Maintenance Ith and Mental Hygie 27 is marked other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked viury or other traumatic ev Laura Spence <u>Norwood Bivens</u> 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21851 Evette Bivens-Curtis, Oak St. Pocomoke, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-24-2012 Macedonia Mem Pk Westover, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Bennie Smith 917 W. Isabella St. Funeral Salisbury. Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Immediate Cause (Final Onset and Death PSUS Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant a 9 ☐ Unknown 5 Other (specify) Month 1 Yes 2 No Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅌ 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatl 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1/C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 3TC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STAVANTAY PATAPONLA 2/80/

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Mont I, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Harold Edmund Brown 8:15 November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) 129-22-8566 Director 1 X M 2 □ F 83 10/06/1929 New York Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, <u>the Medical Examiner must be notified at</u> 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Tulip Drive 20877 United States 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No 19 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1952 δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 1954 Completed Specify: White 3 🕅 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Engineer Federal Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester J. Brown Autumn Law 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Padraic Brown/Son Hutton Street, Gaithersburg, MD 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 X Removal from State 11/26/2012 Metropolitan Crem. Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home May MD 20877 MO1202 10 E. Deer Park Drive, Gaithersburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician eun disease or condition Medical resulting in death) Examiner Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the attending physician and the for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2. No 3 ☐ Probably 4 ☐ Unknown 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ျှ 1X Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? Investigation 2 🗆 No within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in murciples. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier P 29d. Date signed (Month, Day, Year) 0062435 9+1 (Print) 30. Name and address of person who 23a) (Type, Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOV 2012 IRENE BURGER Medical 1515 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Dav. Year) Director 214-52-3751 1 M 2 XF Usual Residence of Decedent 63 JAN. 9, 1949 WASH. D.C. I and 2 should be filed within 72 hours after death with the Maryland f Heaith and Mentai Hygiene. It Heaith and Mentai Hygiene. Item 27 is marked other than 'natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner nust be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. MONTGOMERY 1 Yes 2 □ No TAKOMA PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 430 ETHAN ALLEN AVE. 20912 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 SECRETARY ELECTRICAL UNION #26 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE C. SIGMON FLORENCE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA E. HOPKINS/SISTER 22551 WINDMILL RD., MILLSBORO, DE. 19966 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of I
Important: If It
any Injury or of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 11-26-2012 RIVERDALE, MD. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P. A CLEVELAND AVE. M00091 5801 RIVERDALE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner GENERALIZED SEIZURES Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and complement filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown Day 9X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No B 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 🖾 No ည 1 X Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D71462 NOV. 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANILA DAN M.D8600 OLD GEORGETOWN RD., BETHESDA, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 26 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>Day</sup> 2012 Month Tuyet Thi Bui 4:20 P M Nov. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arcola Health & Rehab. Center Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 212-94-3130 Director 1 🗆 M 2 🖾 F 98 March 22, 1914|Vietnam filed within 72 hours over the Hygiene.
ed other then "neturel", or items 23e or 28e-f shows event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 13805 Baywind Court 20905 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married É ☐ Yes 2X☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Asian If Yes, Give 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) l end 2 should be file f Heelth and Mental H tem 27 is merked of မ Lieu Quy Bui Thuan Thi Pham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hung Viet Trinh/Son 1494 Voyager Drive, Tustin, CA 92782 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pege 1 Department of Importent: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Nov 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signatyre of Funeral Service Licen 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University BLvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that collect the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition mos Medical resulting in death) Due to (or as a consequence of): Examiner <u>Senile Dementia</u> equentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ettending physicien end I for use as the burlai-transit or Attending Physicien: The lew requires that the deeth certificate be executed Hypertension Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 Congestive Heart Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day ed by the deteched Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Adenocarcinoma of Colon 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed certificete hes been si lirector, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physicien: The Within 24 hours after deeth.

To the Funerel Director: After this certificets completely filled in by the funerel director, pe 2 🗌 No 1 Yes Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending 1 🗌 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar 7505 New Homphy To Avenue #310.

Takowa Park, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signature

TON THAT CHIEU,

26

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Ma		partment of F ertificate of D			iene <sub>eg. No.</sub> 20	2 40389
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Med Exami	ical	Gertrude Elizabeth  4a. Facility Name (if not institution, give street and number)	Blankens	<del></del>	Location of Death	Novembe	4c. County of	
	F	607 Whittington Place  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Deale If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Anne An	runde1  Birthplace (State or Foreign
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land show dat	ţō	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Le	ocation				10d. Inside City Limits
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s 23a o	Funeral Director	607 Whittington Place			.0751		U.S.A	
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ò	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced  12. Was Decedent Every Armed Forces?  1 ☐ Yes 2 ☒ N  If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		cify Yes or No- Rican, etc.)		American Indian, White, etc. white
15-0 72 hours "natur edical l	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa kind of work done o		ng	16b. Kind of Busin	ness Industry
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laryl should and Me is marl	3	19a. Informant's Name/Relationship (Type, Print)	1	ling Address (Street a	and Number or Rura	l Route Number,	City or Town, State	
and 2: Health tem 27		Janice Moreland, daughter 20a. Method of Disposition	705 20b. Place of Disp	Kingfishe			D 20751 20c. Location - Cit	ty or Town. State
		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cre	ematory or other plac Ltan Crema	e) [		Alexandr:	·
Baltimo permit. Page Department. Important: If any injury or		21. Signal of Funeral Service Licensee		22. Name and Addres				e, P.A. 20736
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/ <b>60</b> ate be executed physician and the burial-transit	edical Ex	resulting in death) Last Due to (or as a	consequence of):					
Certificate be executed reding physician and use as the burial-transi	Medi	IF FEMALE:					T	
DIVISION OT VITAI RECORDS, P.O. BOX 68/7 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23h Was decedent pregnant 23c. If yes, outcome of	! ☐ Fetal death 3	☐ Ectopic pregnanc☐ Other (specify)	у		23d. Date o	
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DIVISION OT tal or Attending PI rs after death. al Director: After th ed in by the funeral	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur- building, etc.	y - At home, farm, st (Specify)			28f. Location (Stre City or Town,		r Rural Route Number,
le Hospit n 24 hour e Funera	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of many many many many many many many many	amination and/or inves	stigation, in my opinio	n, death occurred at	the time, date and	place, and due to	the cause(s) and manner stated.
To th within To th comp	-	29b. Signature and title of certifier	10	29d license	nymber 25hd-		d. Date signed (M	
den 2		30. Name and address is performed by present cause of dec	ath (Item 23a) (Type,	Pilkangeri	AWA C	60241	More	40]
Sta Registi		31. Date filed (Month, Day, Year) 32. Registre	's Signature	parker				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	of Maryland /	Department of F			iene eg. No. 2012	40390				
ı	Physicia		1. Decedent's Name (First, Middle, Last)  Mary Jane Burdock				2. Date of Deat Month 1 1		3. Time of Death 9:08 P M				
-	Medic Examin		4a. Facility Name (if not institution, give street and r WMHS Frostburg Nursing&I			Location of Death	11	4c. County of Death					
	Funeral Director		5. Social Security Number  220-26-9418  Usual Residence of Decedent  6. Sex  1 □ M 2   ✓	7. Age (In yrs. last b	irthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apri		lace (State or Foreign ry) ryland				
	aryland a-f show fied at	Director	10a. State 10b. County  Maryland Allegany		wn or Location			11	0d. Inside City Limits 1   Yes 2 □ No				
	th the Ma 3a or 28a t be noti		10e. Street and Number 48 Tarn Terrace		10f. Zip Code 21532-		1	0g. Citizen of What Coun U.S.A.					
	death w	/ Funeral	Armed	ecedent Ever in U.S. Forces?	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e					
0036	ours after tural", or al Exami	ted by	3 X Widowed 4 ☐ Divorced If Yes, Year or	Dates.	1 🗆 Yes 2 🕅 No	Specify: Wh	ite						
1215-	e filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College 12 0	ed) 16 (1-4 or 5+)	ia. Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired) owner/ operator	ation <i>luring m</i> ost of workir	ng	16b. Kind of Business/Inc	,				
Baltimore, Maryland 21215-0036	I be filed with the filed with the filed other fice event, the fice of the file event, the filed with the filed	To Be (	17. Father's Name (First, Middle, Last)  Anthony Drees		owner, operator		(First, Middle, Mosenberger	convenience store p, Maiden Surname) er					
Mary	12 should be fil alth and Mental <b>27 is marked o</b> r traumatic eve	8	19a. Informant's Name/Relationship (Type, Print)  Shirley Winner sis	T.	9b. Mailing Address (Street a		Route Number,	City or Town, State, Zip C <b>Maryland</b>	ode) 21532-				
more,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal fro  4 □ Donation 5 □ Other (Specify)		of Disposition (Name of tery, crematory or other plac <b>Finzel Cemetery</b>	e) [		20c. Location - City or To	wn, State <b>Maryland</b>				
Balti	permit. Pepartm Departm Importa any inju		21. Signature of Funeral Service Licensee	w/f	22. Name and Addres		Frost Ave.	, Frostburg, MD	21532				
	Physician/	/-2	23a. Part A. Enter the disease, or complications the shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	each line.	onot enter the mode of dying	12			Approximate Interval Between Onset and Death				
	Medical Examiner		resulting in death) a. Due	to (or as a consequence	e of):	U WIFF	lown o	n one	month				
	ted Insit	ıminer	cause. Enter Underlying Cause (Disease or injury	lo (or as a sonssquence	s orj:								
0	cate be executed physician and s the burial-transit	cal Exa		to (or as a consequence	e of):								
Box 68760	artificate ding physice as the	/Medi	d	outcome of pregnancy									
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Medical Examiner	in the past 12 months?	ve Birth 2 🔲 Fetal dea egnant at time of death		у		23d. Date of delive Month	ry Day Year				
Records, P.O.	uires that ti n signed by uld be deta	by	Part II. Other significant conditions contributing to	o death but not resulting	g in the underlying cause giv	en in Part I.		acco use contribute to the					
Secor	he law req te has bee bage 2 sho	Completed					24a. Was an autops perforn	y prior to con ned? death?	sy findings available npletion of cause of				
/ital F	sician: The law r certificate has b lirector, page 2 s	To Be C	25. Was case referred to medical examiner? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)  Hospital:	☐ Inpatient 2 ☐ ER/0	Othe	ace of Death (Check	only one)	nce 6 Other (Specify)	2,52,110				
n of \	iding Phys th. After this funeral di		27. Manner of Death  1 Natural 5 Pending  (M		. Time of 28c. Injury work	at 2		w injury occurred					
Division of Vital	l or Atter after dea Director: d in by the	Certificate:											
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	Medical											
	To the within to the comple		29b. Signature and title of certifier	, MD	29c. License			9d. Date signed (Month, E					
			30. Name and address of person who completed co	ause of death (Item 23a)	(Type, Print)		9 / 6	land Mg	2100				
	Misc. Stat	e	31. Date 100 V073 Bay 2012 Lessen	Registrar's Signature	ishor Wals	n Kg (	am <del>pe</del>	riune My	CISUL				
	Registra	ir	penso	1 1									

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RAMONA LYNN BETTS November 2012 3:40 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3231 Lawsonia Road Crisfield Somerset Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 05/13/1962 1 M 2X F Months Hours Maryland 220-74-6920 Director 50 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits Director Maryland Crisfield 1 Yes 2 No Somerset 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 3231 Lawsonia Road 21817 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: White and Mental Hygiene. is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard Burke Elmira Goldsborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Elmyra Betts (Daughter) 3231 Lawsonia Road - Crisfield, MD 21817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If itel any injury or oth 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 11/16/2012 Delmar, DE ert H. Brac 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.-Crisfield, M Signature Bradshaw, Jr Robert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner man He Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): death certificate be executed for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Month Pregnant at time of death should be detached 9 Unknown P.O. I The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform completed filled in by the funeral director, page 2 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 **R**io 2 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: atural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated configuration. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

est suite 105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

32. Registrar's Signature

31. Date filed (Month, Day, Year)

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or							-		_	ible.		
		For State		State of	f Marylan					and M	lental Hy	giene	9			
		Registrar  1. Decedent's Name	e (Eiret Middle	I act)		Ce	rtificat	e of L	eatn		2. Date of Dea	Reg. No	20	12	40392	
Physicia		Lawrence									Month Novembe		20	Year	3. Time of Death 6:30 A <sup>M</sup>	
Medic Examin		4a. Facility Name (if		- 00	ber)		4b City	Town, or	Location of	of Death	Novembe			of Death		
Examili	C1	Golden Li			/			reder		, Doda.		"		derio		
Funeral		5. Social Security No	umber (	3. Sex	7. Age (In yrs. I		If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Birt			9. Birth	place (State or Foreign	
Director		217-28-60		1 🐼 M 2 🗆 F	8	4 Yrs.	Worths	Duys	riouis	1911) 1.	Feb. 18		28		yland	
nd how at	'n	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or L	ocation								10d. Inside City Limits	
faryla 3a-f s tified	ect	Maryland	Frede	rick	F	rederi	ck								1 🗌 Yes 2 🔀 No	
the N	Funeral Director	10e. Street and Nun		TICK	1 1	reacri	10f. Zip	Code				10g. Ci	itizen of \	What Cou	ntry?	
s 23a	era	6010 Bart	tonsvil	le Road				2	21704			Uni	ted :	State	es	
death item		11. Marital Status		Armed For	dent Ever in U.S	S. 13.	Was Dece	dent of His cify Cubar	spanic Ori	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)			e - Americ ck, White,	can Indian,	
after al", or xami	d by	1 Never Marri				n	1 🗌 Yes	2 🔀 No	Specify:				Specify:		ack	
hours natura ical E	Completed		15. Decedent		tes. War		dent's Usu					16b. k	Kind of B	usiness/In		
in 72 e. nan "r	dmc	(Spe		t grade completed)  College (1-	4 or 5+)		kind of wo		uring mos	t of worki	ng				,	
withi /giene ner th	ပို	6	oncre	te Wo	rker			Cor	nstr	uctio	on					
e filed ttal Hy ed ott	To Be	17. Father's Name (First, Middle, Last) (unobtainable)  18. Mother's Name (F									e (First, Middle, Maiden Sumame)  Biggus					
uld be d Men marke natic		40 17	/D. I	T. Dist		T										
2 sho th and 27 is i	19a. Informant's Name/Relationship (Type, Print)  Catherine Biggus / Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or To 6010 Bartonsville Rd., Frederick,															
I and I Heal		20a. Method of Disp		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20b. F	Place of Disp	osition (Nar	ne of							own, State	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			☐ Cremation : 5 ☐ Other (Sp	3 Removal from		Resth			e)	Nov.	012	Fre	-der	ick.	Maryland	
mit. F partin porta y inju		21. Signature of Fur			, ric		al Gardens 2012   Frederick, Maryla Restrated for Funeral Services, Skkot Cody P.A.									
88 = 84			9	//		9	501 C	atoct	in M	ount.	ain Hwy	. F1	rede	ot Cody P.A. derick, MD 21701		
_		23a. Part 1. Entert shock, or near	ne disease, o c rt failure. List on	omplications that cally one cause on each	aused the deat ch line.	h. Do not en	ter the mod	le of dying	, such as	cardiac o	or respiratory an	rest,			Approximate Interval Between	
Physician/		Immediate Cause ( disease or conditio resulting in death)	Final	a		Po	uln	re	L	0	1/1	20	re	$\perp$	Onset and Death	
Medical Examiner		resulting in death)	1	Due to (d	or as a consequ	uence of):				1	tran					
	Jer	Sequentially list coif any, leading to im	nditions,	b. Due to (c	or as a consequ	uence of):	2		~e	~V	101			+		
ansit	Examiner	cause. Enter Under Cause (Disease or	rlying injury													
executed an and rial-transi	Ë	that initiated events resulting in death) I		Due to (c	or as a consequ	uence of):					·.					
ath certificate be executed attending physician and for use as the burial-transit	by Physician/Medica			d										$\rightarrow$		
artifica ling p	/Me	IF FEMALE:		23c. If yes, outo	come of progra	In CV										
ath ce attenc for us	cian	23b. Was decedent in the past 12 r	months?	1 🔲 Live E	Birth 2 Feta ant at time of c	al death 3	Ectopic Other (s)		У					ite of deliv onth	very Day Year	
y the conclusion of the conclu	hysi	1 Yes 2 9 Unknown		g 🗆 Unkn		30411										
requires that the des been signed by the s should be detached	oy P	Part II. Other signif	icant condition	s contributing to de	eath but not res	ulting in the	underlying	cause giv	en in Part	l.	23e. Did to	obacco	use cont	ribute to t	the cause of death?	
quires en sig ould b											1 🗆	Yes 2	□ No	3 Pro	obably 4 Onknown	
aw rec as be	Completed										24a. Was	psy		prior to co	opsy findings available ompletion of cause of	
rsician: The law <i>v</i> certificate has b director, page 2 s	Con										perfo	rmed?		death? 1 🗌 Yes	2 🗌 No	
ician: certific rector	Be	25. Was case referre	_/	Hospital:				Othe	ce of Dea	/						
Phys r this eral dii	<u>۲</u>	1 Yes 2 2 27. Manner of Death	Mo h	28a. Date o	npatient 2  of injury	ER/Outpatie		OA Dano 28c. Injury	4 LY N		me 5 Residence 128d. Describe h				γ)	
nding th. : After e fune	cate	1 Natural 2 Accident	5 Pending	(Mont	h, Day, Year)	injury	м	work			zod. Describe i	low inju	ry occurr	5G		
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tal or rs afte al Dir led in	building, etc. (Specify)  City or Town, State)															
Hospi 4 hou Funer tely fill	Second   S								ted. ause(s) and manner stated.							
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Me	only one) 3 29b. Signature and		Nurse Practitioner:	To the best of r	ny knowledg		curred at the		te and pla	ace, and due to t				stated.  Day, Year)	
F ≥ F 70				4.0	MAX		250	$\mathcal{I}$	55	)2	91	1	1/1	9/1	2	
		30. Name and addre	ess of person w	ho completed cause	e of death (Item	23a) (Type,	Print)		ن ري		/ / A	//	1/	1	0 = 0	
(s)		SAJJI	AD	A=12,	MD	-81	2]	Tal	111	ow	of A	Ve	17	ne	derich	
Stat		31. Date filed (Monta	h, Day, Year) NOV 2 (	2012 32. Re	strar's Signa	ture	park	1					/	MD	21701	
Registra	ır		HOT Z	0 2014	ensur	10.	7								, 10	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20astate of Mary 6934 Decartment of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Samuel Coates 06:07A. Medical November 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Upper Marlboro, Director 577-46-1299 1**X** M 2 □ F 78 12/18/1933 Maryland Usual Residence of Dece r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10h Count 10c. City, Town or Location within 72 hours after death with the Maryland 10d, Inside City Limits Director D.C. Washington 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4915 Jay St., N.E. 20019 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1½ Yes 2 ☐ No
If Yes, Give 159—161 Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🖳 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Clerk Liquor Store 1 and 2 should be filed wir if Health and Mental Hygie item 27 is marked other other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Coates Zola Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian S. Coates/Nephew 511 Fern Pl., N.W., Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State MX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico Nationar cem 12-10-2012 Triangle, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry S. Washington & Sons Co, Inc. 4925 Burroughs Ave., N.E., Washington, D.C. CC0316 rall any 20019 231. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Metastatic Colon rancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) igned by the attending physician and be detached for use as the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pronanu 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 1 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Hipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniun 1 Anatural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, To the Hospital within 24 hours of the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and one to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D68005 225hadi November, 26th 2012 mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Carroll Avenue Takona Park, md 20912 Object MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Maryland 21215-0036

Box 68760

Division of Vital Records,

				Plea	ase Type or									•	ble.	
				For State Registrar	State	of Maryla	-	artme rtifica:			and N	/lental Hy	/gien Reg. N	0 0 1	2	40394
				Decedent's Name (First, Middle	, Last)		00	inca	- OI L	Caur		2. Date of D		10C U	<u></u>	3. Time of Death
	Physic Me			Carribelle Con	nway							Month Novem	ber	19. 2	Year 2012	6:51 a <sup>M</sup>
and of	Exan			4a. Facility Name (if not institution,	, give street and nur	nber)		4b. City	, Town, or	Location	of Death			c. County of		
Section 2				Holy Cross Hos	pital 6. Sex	7 4 //	to a b bat do b			Sprin		12 - 22	$\perp$	Mon	tgom	
н	Funer Directo			579-40-3692	1 □ M 2 <sup>X</sup> F	7. Age (In yrs. 87	**	Months		Hours	Min.	8. Date of Bi (Month, D	ay, Year)		9. Birthpl Counti	ace (State or Foreign y)
	, we			Usual Residence of Decedent		L,						Dec. 9	, 19	124	Wash	ington, DC
	ryland -f she ied at		cto	10a. State 10b. County		10c. C	ity, Town or Lo	cation							10	Od. Inside City Limits
	or 28a			MD Mo	ontgomery		Silver		ng p Code				10- 0	No		1 🗓 Yes 2 🗆 No
	with the		Funeral Director	9021 Fairview	Road			101. 21	2091	Λ			US	Citizen of W	nat Count	ry?
	items items		Ē	11. Marital Status	12. Was Dece	edent Ever in U		Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No			- America	ın Indian,
36	after c		2	1 Never Married 2 Marr	16 Ven C:	2 🔀 No		_		Specify:		Rican, etc.)		Black Specify:	White, e	
8	atural cal Ex		Completed by	3 Widowed 4 Divorced	Year or D	ates.										
215	n 72 h an "n Medi		Ē		est grade completed		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  or 5+)							Kind of Bus	siness/Ind	ustry
2	ygiene ygiene yer th				4	-4 OI 3+)	Hom	emake	r				l Ow	n Hom	ie	
and	e filec ed ot		lo Be	17. Father's Name (First, Middle, L	,							e (First, Middle				
چ	d Mer mark matic	ľ		Fred Lewis Wat		<u>-</u>	T					nriett				
<b>∑</b>	12 shallth an 27 is r trau			Paul R. Conway								own, M			ate, Zip Co	ode)
ore,	of Her fitem		1	20a. Method of Disposition			Place of Dispo cemetery, crei	sition (Na	me of			Date OV. 26		Location - 0	City or Tov	vn, State
Ë	Page ment tant: I			1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			rge Wa				ery	2012	Ade	elphi,	, MD	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ouce.		21. Signature of Funeral Service	icensee 1941	_	F	Name a	nd Addres	s of Facilit	ins	Funeral				
	00=0	1	4	23a. Part 1. Enter the disease, or	A) / Culle		[5]	00 Un	iver	sity_	<u>Blvd</u>	. W.,	<u> 311v</u>	er Sp	ring.	MD 20901
			0	shock, or heart failure. List o	nly one cause on ea	ich line.	un. Do not ent	er the mod	ie or ayıng	, such as	cardiac d	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	hysiciar Medica			disease or condition resulting in death)	a. Seps:	ĹS (or as a consec	uence of):									Silost and Boats
	Examine	■.		Sequentially list conditions,		cation		nia								
_	T 50	Fyamine		if any, leading to immediate		(or as a consec										
	executed an and rial trans		E	Cause (Disease or injury that initiated events resulting in death) Last	c. UTI	or as a consec	unance of:									
	be ex sician buria	13	ŧΙ	resulting in deathly East		e Renal		-0								
Division of Vital Records, P.O. Box 68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial transitional transitions.	Completed by Physician/Medic			d. Acute	Kenar	rallui	е								
% %	endin r use	2		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn Birth 2  Fet	ancy	Ectopic	pregnance	,			ļ	23d. Date	of deliver	y
Bo	deatl the att hed fo	icio	5	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		nant at time of		Other (s)						Mont	th [	Day Year
Ö.	at the	Ę		Part II. Other significant conditio	ns contributing to d	eath but not re	sulting in the u	nderlying	cause give	en in Part I		23e Did t	obacco	use contrib	oute to the	cause of death?
S, I	uires the signer of signer	٦	Š	Hyperglycemia												ably 4 🔀 Unknown
ord	w requ	plete										24a. Was	an	24b. W	ere autops	sy findings available
Bec	The la	Į,	[					7.5.40				auto perfe	ormed?	de	iortocom ath? ∐Yes 2	pletion of cause of
ta [	cian: ertifica ector,	Be C		25. Was case referred to medical examiner?	TO-MINISTER OF				26. Pla	ce of Deat	h (Check		2 (44)	101	103 2	. La No
<u>`</u>	Physion this control direction	ļ.	2	1 Yes 2 No 27. Manner of Death		Inpatient 2				4 ∐ Nu		me 5 🗌 Resi				
פֿי	nding th. : After e fune	150	1 Natural 5 Pending (Month, Day, Year) injury work?								how inju	ry occurred	l			
isio	Atter er dea ector by the	Įį.	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined determined								or Rural F	Route Number,				
<u>`</u>	ital or irs afte al Dir led in				buildi	ng, etc. (Specif	y)					City or Tov	vn, State	e)		
	In the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic second process. In the funeral director, page 2 should be detached for use as the the funeral director.	Medical		(Check 2 L Medical Ex	Physician: To the b xaminer: On the bas	is of examination	on and/or invest	idation, in	my opinior	n, death oc	curred at	the time, date a	and place	e and due t	o the caus	e(s) and manner stated
	o the vithin of the comple	, Š		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitioner	To the best of	my knowledge	death occ	urred at the	e time, dat	e and pla	ce, and due to	the caus	e(s) and ma ate signed (	nner as sta	ated.
ه	->- 46	-		> m Ral	may	1Far			6637					7. 19,		
			-	30. Name and address of person w	vho completed caus	e of death (Iten	n 23a) (Type, F						110 0	,	201	-
		1		Majid Rahmania:		500 For	rest G1	en Ro	ad,	Silve	er Sj	oring,	MD 2	20910		
	St Regist	ate trar		NOV 2 0 2		egistrar's Signa	pure face	Kad								

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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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	•	For State Registrar	Otate of	iviai yiaria		tificate of D		aria ivi			1.0	10005	
		Decedent's Name (First, Middle	2. Date of Death 3, Time of Death										
Physicia Medic		Raymond Feng Ch	November 14, 2012 1707 M										
Examin	er	4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death			
Funeral		Shady Grove Adventist Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)				Rockville  If Under 1 Year If Under 24 Hrs. 8, Date of Bir				Montgomery  h 9. Birthplace (State or Foreign			
Director		115-26-3263 1 ▼ M 2 □ F 79			Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	Count	Country)	
т М		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town								1, 1933			
ıryland I-f sh ied at	ctor	Maryland Montg	y Village 10d. Inside City Limits						0d. Inside City Limits				
or 28	Funeral Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?										
23a		9713 Digging Ro	20886		United								
items items	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?				. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American Indian,		
after (	l by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.				· □ · · • ▼ · · · ·					Black, White, etc. Decify: Asian		
atura cal E	To Be Completed	15. Deceden	ф						hinter				
n 72 t an "n Medi		(Specify only highe: Elementary/Secondary (0-12)	kind of work done during most of working						stitutes				
ygiene ygiene her th		meart brook bung Research of nea								1th			
e filec tal H ed otl		17. Father's Name (First, Middle, L Conrad Ch	18. Mother's Name (First, Middle, Maiden Surname)  Evelyn Chu					ne)	İ				
ould b		19a. Informant's Name/Relationsh	. 1										
12 shall ar alth ar 27 is r treu		Roger Griffin/S				g Address (Street a Digging H							
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at any injury or other treumetic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition		20b. Plac		sition (Name of patory or other place		D	ate	20c. Location	- City or To	wn, State	
Page ment cant ant: It ury or		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			-	Cemetery		ov.17	7,2012	Germant	own,	MD	
permit. Depart		21. Signature of Funeral Service	1111			. Name and Addres				7 Park			
⊕ CD == 66 OI		M00956 Thibadeau Mortuary Svc pa Gaithersburg, MD 20877  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											
Physician/ Medical	5	shock, or heart failure. List o	nly one cause on each	line.		10.20						Approximate Interval Between Onset and Death	
	by Physician/	Immediate Cause (Final disease or condition resulting in death)  a. acute dysrhythma  Due to (or as a consequence of):  Coronary artery disease								-	Onset and Death		
Examiner			. Due to (or	oron	ani	arter	40	Lisa	ease				
- ±0		if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):											
and and transi		Cause (Disease or injury that initiated events											
e e e		resulting in death) Last Due to (or as a consequence of):											
icate to physis the			d										
eath certificate b a attending physi d for use as the k		IF FEMALE: 23b. Was decedent pregnant	y looth 2	I control to the control to				23d. D.	23d. Date of delivery				
death ne atte ed for		in the past 12 months?  1  Yes 2 No	Ectopic pregnancy Other (specify)				Month Day Year						
<b>hysician:</b> The law requires tha his certificate has been signed al director, page 2 should be d		9 Unknown 9 Unknown											
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown				
	Completed											sy findings available	
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		examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2 ER/Outpatient 3 DOA  Other:  4  Nursing Home 5  Residence 6 Other (Spec											
		27. Manner of Death 1 Natural 5 □ Pending		Bb. Time of injury	28c. Injury work?	,	- 1	8d. Describe h	ow injury occur	red			
Attenc death ctor:		2 Accident Investig 3 Suicide 6 Could r	not be	Injury - At home	M 1 ☐ Yes 2 ☐ No  At home, farm, street, factory, office 28f. Location (Street and Number or					er or Puml	Pauto Number		
al or / s after Il Dire		4  Homicide determi	building, etc. (Specify)										
the Hospitathin 24 hours the Funerathe Funerampletely fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										d.	
		201 01-1-1										ated.	
4 3 4 D		29b. Signature and fiftle of certifier 29c. License number 29d. Dat								29d. Date signe	ate signed (Month, Day, Year)		
		30. Name and address of personwing completed cause of death (tem 2/3) (Tune Print)								וטכאווי	172012		
		29c. License number 29d. Date signed (Month, Day, Year) November 14 2012  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orlee Panitch, MD 9901 Medical Center Drive, Rockvillt, Mogland 20850											
Stat	е	31. Date filed (Month, Day, Year)  NOV 20	32#Rea	istrar's Signature	ha	del							
Registra	ır	NUV 2 U	CUIL LAW	un po	17"	we full as							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month рΜ Isabel Castillo Medical Nov. 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Patuxent River Health & Rehab. Cente Laurel P.G If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director 061-72-6064 1 M 2 XF April 4, 1920 Dominican Republic Usual Residence of Deced init. Pege 1 end 2 should be filed within 72 hours after death with the Maryland entment of Health end Mental Hygiene. ortent: if item 27 is marked other then "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD PGBeltsville ۵ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4605 Barbara Drive 20705 Dominican Republic 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ۵ 1 Never Married 2 Married Maryland 21215-0036 1₺ Yes 2□No SpeciDominican If Yes Give Specify: White 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ٥ Manuel Serrano Anita Castillo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Peguero/Daughter 4605 Barbara Drive, Beltsville, MD 20705 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 20 20c. Location - City or Town, State permit, Pege 1 e Depertment of H importent: If ite 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 2 Sichard Z ales 500 University Blvd. W., Silver Spring, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician end or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 signed by the ettending physical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 23e. Did tobacco use contribute to the cause of death? Hypertension, Dementia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funarai Director: After this certific Tompletely filled in by the funeral director. 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) examiner? Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🖾 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nufse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 2 0 2012

53411

14300 Gallant Fox Lane, Bowie, MD 20715

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jagdish Shesadri, MD 14300 Gallant Fo

29d. Date signed (Month, Day, Year)

Nov. 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1150AM 2012 Collins Duenus Dorothy Μ. Medical 4a. Facility Name (if not institution, give street and number, 4b-Gity, Town, or Location of Death Examiner 4c. County of Death Brocke Grove Rehabilitation and Nursing Center andy lontgomery Spino 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yo May 13, 9. Birthplace (State or Foreign FL Country) **Funeral** 418-32-5323 1 🗆 M 2 🖾 F Days Hours Director May Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified 1 Yes 2X No MD Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13128 Manor Drive 21771 IISA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 SpecifWhite 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Joseph O. Armand Rose Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13128 Manor Drive, Mt. Airy, MD 21771 Matthew D. Collins/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Nov. Alexandria, VA Metropolitan Crematory 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Alzheimer's Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attendion abusinan and resulting in death) Last Due to (or as a consequence of). attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No signed by the atte Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a, Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertliving Number Fractioners To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

30. Name and address

Tale Show.

Date filed (Month, Day, Year)

of person who completed cause of beath (Item 23a) (Type, Print

M.D. 18100

		_ For	Plea						. Ensure A Health and M	-	_	jible.	
		1 - State Registrar					Cei	rtificate of	Death		Reg. No.	112	1.0398
Physicia		1. Decedent's Nam	ne (First, Middle	, Last)						2. Date of Dea Month	ath Day	Year	3. Time or Death
/Medic		Veronica	a L.	Colfer						Nov. 20	Day 201	2	6:56 PM
Examin	er	4a. Facility Name (			number)				or Location of Death			ty of Death	
7.00		Sacred I		6. Sex	7 A	o //p i/ro	last birthday)	Hyatts	sville	8. Date of Birt	P.G.		place (State or Foreign
Funeral Director		577 <b>-</b> 34 <b>-</b> 98		1 M 2 M	1 3	00	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Cou	ntry)
		Usual Residence o								April 0	, 1912	PAIN	
ryland how		10a. State	10b. County			10c. City	y, Town or Lo	ocation					IOd. Inside City Limits
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ath w	Funeral Director	5805 Que	eens Ch					2078			USA		and the disease
er de item:	nne	<ol> <li>Marital Status</li> <li>Never Mari</li> </ol>	ried O Morr	Arme	Decedent d Forces? es 2 📆		.S. 13.	Was Decedent of F If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puert	oecity Yes or No- o Rican, etc.)	ВІ	ace - Ameri ack, White,	etc.
rs aft I", or xami	by F	3 XWidowed		If Yes	Give or Dates:	NO		1 ☐ Yes 2 🖾 No	Specify:		Spec	<sub>sify:</sub> Whi	te
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t and Health	4.3	20a. Method of Dis				20h F				Date Date	20c. Location		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2	Cremation	3 □Removal fr	om State			osition (Name of matory or other pla	, 110)	7 23	Alexan	,	
it. Partmel		4 □ Donation  21. Signature of Fi	5 Other (S			met		tan Crema					VA
perm Depa Impo any i		21. Signature of the	resch 1	1. Lots	M	0150	0 2		es Collins				ND 20001
MATERIAL SE		23a. P. m. Enter	the disease, or	complications th	nat cause	d the deat	1.0		ng, such as cardiac			Sprin	g,MD 20901 Approximate
Physician		shock, or hea Immediate Cause	art failure. List	only one cause	on each !	ine.	1241	rentio	-				Interval Between Onset and Death
/Medical		disease or condition resulting in death)	on	a	to (or as	a conseq		iencio	1				Unknown
Examiner				b	·								
D #	ner	Sequentially list co if any, leading to in cause. Enter Under	onditions, mmediate erlying		to (or as	a conseq	uence of):						
executed in and intransit	Examiner	Cause (Disease or that initiated events resulting in death)	r injury S	c									
	_	resulting in death)	Last	Due	e to (or as	a conseq	uence of):						
The law requires that the death certificate be tte has been signed by the aftending physicis age 2 should be detached for use as the but	Physician/Medica			d									
leath certific aftending p	/Me	IF FEMALE:	. 4.	23c. If yes	outcome	of pregna	ancv				004 [	ate of deliv	
aften for u	cian	23b. Was deceder in the past 12 1 ☐ Yes 2		1 □ Li	ive birth	2 ☐ Feta	Ideath 3	☐Ectopic pregnanc ☐ Other <i>(specify)</i> _	y			Date of deliv Month	Day Year
the de	ysic	1 ∐ Yes 21 9 ☐ Unknowr			nknown	a anno or a	odai o E	_ calci (opcony) _					
that the ned by the detack	by Pr	Part II. Other signi							ven in Part I.	23e. Did t	obacco use co	ntribute to	the cause of death?
quires in signi uld be	q p		Adul-	L fai	Jur	e t	o the	rire		1 🗆 '	Yes 2 □ No	3 ☐ Pro	bably 4 Unknown
aw requir s been si	Completed		HVD	erna	tre	mi	a			24a. Was			opsy findings available
siclan: The law certificate has t irector, page 2 s	mo		11	er ma	Lon	(10	<u>~</u>			autor perfo 1□ Yes	rmed2	death?	ompletion of cause of 2□ No
	BeC	25. Was case refe		7 / 6/	7-67	<i></i>			26. Place of Sea				
2 .2 ₽	은	examiner? 1 ☐ Yes 2☐	No	Hospital:	l 🗌 Inpati	ent 2 □	ER/Outpatier	nt 3□ DOA Oth	ner: 4 Nursing H	ome 5 ☐ Resi	dence 6 🗆 C	ther (Speci	fy)
		27. Man of Dear	th 5 <b>□ Pe</b> ndin	/	ate of Inj Month, Da		28b. Time o Injury	Wo	ry at rk?	28d. Describe I	how injury occ	urred	
	catio	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could r	ation					]Yes 2 □ No				
or Attendater death Director:	Certification:	4 ☐ Homicide	determ	200. F	lace of in uilding, e	jury - At ho tc. <i>(Specif</i>	ome, farm, sti <i>y)</i>	reet, factory, office		28f. Location (3 City or Tox	Street and Nui vn, State)	nber or Rur	al Route Number,
Hospital 24 hours a Funeral L		29a. Certifier	1 D Cortifyin	a Physician: To	the heet	of my kno	wledge deat	th occurred at the ti	ime, date and place	and due to the	cause(s) and	manner as	etated
To the Hospital or At within 24 hours after de To the Funeral Director Completely filled in by	Medical	(Check only one)		Examiner: On t		of examina			opinion, death occu				
To the within 2 To the Comple	Me	29b. Signature and						29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)
15			Ch	wde	7		)	D4	3/21		11/2	3/17	
·		30. Name and add	lress of person	who completed	cause of	death (Iten	n 23a) (Type,	Print)	-, ,			ŧ	
		NURUL	CHO	NDHUI	24,	MD,	1605	5 Main	St, La	urel,	MD 2	070	7
Sta		31. Date filed (Mor	nth, Day, Year)	3	2. Regist	rar's Signa	ature	4.3					
Registr	-	NO	V 262	U12 Se	nous	, ß.	Mar		5+, La				
IMH 17 Day 1/20	101			-	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	partment of Health and M			10200
			State Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death		Na2012	
	Physicia		Gloria Jean Cullers		2. Date of Death November	18, 2012	3. Time of Death 4:19 P.M
mage.	Medio Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	n
			Anne Arundel Medical Center	Annapolis		Anne An	
	Funeral Director		5. Social Security Number 217-44-2582 Usual Residence of Decedent  6. Sex 1 □ M 2 X F 63 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) 07/08/194	ear) Cou	hplace (State or Foreign Intry) Cyland
	show dat	tor	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Maryl 28a-f otifie	irec	MD Calvert Lusby				1 🗌 Yes 2 🔀 No
	ith the 23a or st be r	Funeral Director	1825 Striped Bass Court	10f. Zip Code 20657	10g	J. Citizen of What Co. U.S.A.	untry?
	eath w	-une	11. Marital Status 12. Was Decedent Ever in U.S. 1	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Amer	rican Indian,
21215-0036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland fartment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ea.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ⚠ No  3 ☒ Widowed 4 ☐ Divorced Year or Dates.	If Yes, specify Cuban, Mexican, Puerto F  1 ☐ Yes 2 🏋 No Specify:	Rican, etc.)	Black, White	e, etc.
15-0	72 hou "natu edical	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of working	ng 16	b. Kind of Business/I	Industry
12	ithin 7 iene. r than	Con	Elementary/Secondary (0-12)   College (1-4 or 5+)	elf employed	h	ome mainte	enance
pu	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)	<del>-</del>	(First, Middle, Maid		
Maryland	should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	유	Marvin August Tulgetske	Alvert			
2	and 2 shou Health and tem 27 is n		D Olv 1 4 4 1 1 .	ailing Address (Street and Number or Rurai Patuxent Mobil Esta			Code) 20711
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr once.		1 Burial 2 Cremation 3 Removal from State   cemetery, c	sposition (Name of prematory or other place) orial Gardens 11/24		c. Location - City or unkirk, MI	
Baltii	permit. Page 1 a Department of H Important: If ite any injury or ot	54	21. Signatur of Funeral Service Licensee	22. Name and Address of Facility Rau	sch Funer	ral Home,	P.A.
		Н	23a. Part 1. Enter the disease, or complications that caused the death. Do not a	8325 Mt. Harmony La enter the mode of dying, such as cardiac or		gs. MD 20	0736 Approximate
	hysician/ Medical		shock, or heart falure. List only one cause on each line.  Immediate Cause (final disease or condition resulting in death)  a.  Due to (or as a consequence of):	el Infarction	1	-	Interval Between Onset and Death
and .	Examiner		Corman	u arlens	Lisea	00	2007
	p #	niner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	5			2007
	ite be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):	<b>(</b>			<i>300</i> /
09	te be ex nysician he buria	dical	d				
9289	tificate ng ph)	Med	IF FEMALE:				-
Box 6	law requires that the death certificate be executed nas been signed by the attending physician and e 2 should be detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death	3  Ectopic pregnancy 5 Other (specify)		23d. Date of deli Month	ivery Day Year
P.O.	res that the dea signed by the a d be detached i	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds,	require been signature	eted			1 Tes	/~	obably 4 🗌 Unknown
Be	The ate I	Completed			24a. Was an autopsy performed	prior to c	opsy findings available completion of cause of 2 No
ta	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  1  Inpatient 2 FR/Outpa	26. Place of Death (Check	only one)		
of Vital		ate: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury	tient 3 \( \to DOA \) 4 \( \to Nursing Hore  of 28c. Injury at work? 2	me 5 Residence 28d. Describe how i	e 6 □ Other (Speci njury occurred	fy)
sion	I or Attendii after death. Director: Al	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location /Stree	t and Number or Run	al Poute Number
Division	i Šigt		building, etc. (Specify)		City or Town, S	tate)	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  Check  Only one)  1 Certifying Physician: To the best of my knowledge, dear Check  Only one)  1 Certifying Physician: To the best of my knowledge, dear Check Check  Only one)  1 Certifying Physician: To the best of my knowled  Only one)	vestigation, in my opinion, death occurred at	the time, date and p	lace, and due to the c	ause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	29c. License number		Date signed (Month	
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 126709	- 1	11-14-	1
de	w 4		Deboran Brower CRNF. 3015	teeple Char O	103 M	nu trede	ncha
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registry's Signature  NOV 2, 0 2012	Sarkel	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 2 40400 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19 Day 1 Month Charles Ronald Cibulay 201 Zear 1:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center Solomons Calvert Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 127-26-5096 **Director** 1 ₩ M 2 □ F 77 New York 12/02/1934 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔂 No Maryland Calvert Lusby 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12825 McCready Road United States 20657 items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Examiner ō 1 Never Married 2 Married þ 1 Yes 2 💥 No Saltimore, Maryland 21215-0036 1 Yes 2 W No Specify: er than "natural" the Medical Exa Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) US Government Automotive Body Repair marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental t is marked o မ Ferdinand Cibulay Mary N. Benneck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Norma Lee Buckler/ Sister In-Law 580 Wohlgemuth Road, Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 7 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middleham Chapel Cemetery | 11/24/2012 Lusby, Maryland 21. Signature of Funeral Service Lices Rausch Funeral Home, P.A. 22. Name and Address of Facility 5t. P.O. Box 600, Lusby, MD 20657 MT 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** eque (tially) list our critic 16, Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death g Unknown g Unknown ed by the Division of Vital Records, P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy is certificate h director, page 1 Yes 2 No Yes 2 Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending ours after death.

eral Director: Aff
filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) nances D25156 November 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11845 H.G. Trueman Road, Lusby, MD 20657 Charles W. Bennett, MD

State Registrar 31. Date filed (Month, Day,

Registra

12-08647 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Estep Chew State of Maryland / Department of Health and Mental Hygiene 2012 40401 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Robert Estep 2. Date of Death Physician/ Chew Month Day November 14, 2012 **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 1119 Wentworth Drive Oxon Hill Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Davs Hours Foreian Director Country) 214-58-1691 1X M 2 F Yrs 03/24/1951 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County or 28a-f show MD Calvert items 23a or 28a-f shoust be notified at once. St. Leonard Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Higeine.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6950 Marshall Road 20685 USA Ö Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Black 3 Widowed 4 X Divorced If Yes, Give Yaar 1 Yes 2 No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Field Supervisor Construction 10 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Louis Chew, Sr. 011ie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Chew/son 1516 Pacific Ave. Capitol Heights, MD20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State So. Mem. Gardens 11/20/12 Dunkirk, MD Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses <sup>cility</sup> Sewell Funeral Beach Rd. Prince Home, Fred. laden 1451 Dares 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. /Medical a. Carbon monoxide intoxication Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): e attending physician and for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate by 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown icate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Hypertensive atherosclerotic cardiovascular disease, diabetes mellitus Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed death? Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene After this 1 Yes 28a. Date of Injury FOUND: Day, Yaar) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject exposed to toxic fumes 1 Natural FOUND: 1 Yes 2 ✔ No Pending hours after death. Funeral Director: Nov 14, 2012 1215 hrs 2 🗹 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 1119 Wentworth Drive, Oxon Hill, MD determined (Specify) residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated.

State Registrar

29b. Signature and title of certifie

Zabiullah Ali, M.D.

Registrar's Signatur Viena

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

arka

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

November 16, 2012

3. Time of Death

1225 hrs

10d. Inside City Limits 1 Yes 2 No

Between Onset and

Death

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/18/201<sup>Day</sup> Lillian Florence Chaney 1:30 PM M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester 13 Duck Cove Circle Berlin 9. Birthplace (State or Foreign MD Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 1 ☐ M 2**X**☐ F Min Hours 2/14/1921 91 219 03 7639 Usual Residence of Deceder 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Berlin 1 Yes 2X No Worcester 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 13 Duck Cove Circle 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 21 No If Yes, Give Year or Dates. 1 Yes 2 No Specify. 3 □XWidowed 4 □ Divorced Specify white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold M. Walston Lillian P. Dize 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valencia L. McLaren (daughter) 13 Duck Cove Circle, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 $\boxtimes$ Burial 2 $\square$ Cremation 3 $\square$ Removal from State Garden Of Faith Cem. 11/20/2012 Fullerton , MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fun Service License 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a con a quence equentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last

Physician/ Medical **Examiner** 

and

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has

After this

To the Hospital or Attending

Physician/

. Medical

Examiner

**Funeral** 

Director

28a-f show

items death v

"natural",

Ith and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med

Department of Health an Important: If item 27 is n any injury or other traumonce.

Examiner 5

Medical

Director

Funeral

þ

Completed

Be

with the Maryland ms 23a or 28a-f sho must be notified at

3altimore, Maryland 21215-0036

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

physician a s the burial-t Physician/Medical attending pl 2 Completed page 2 should Be မ Within 24 hours area within 24 hours area or To the Funeral Director. After this Certificate:

29a. Certifier

(Check

29b. Signature and title of certific

30. Name and address of person

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year			
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown			
DIA KE	HYPERTENSION)	24a. Was an autopsy performed?  1 □ Yes 2 □ No  24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No			
25. Was case ref_rred to medical examiner?  1  Yes 2 No	26. Place of Death (Check on Hospital:  1	nly one) e 5 🎮 Residence 6 □ Other (Specify)			
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could be	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28b. Time of work? 28c. Injury at work? 1 \( \text{ Yes} \) 2 \( \text{ No} \)	d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	1 28a Place of Injury - At home form street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

60

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2012 Nov. 4b. City, Town, or Location of Death 4c. County of Death Howard Ellicott City If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday)

40403 1 - State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Betty Jane Cunningham 2:30  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4009 High Point Road Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 216-32-7571 Director 1 □ M 2 🏖 F 76 D1/15/1936 MD Usual Residence of Dec or 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location at Director be notified 1 ☐ Yes 2 K No MD Howard Ellicott City 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral **Examiner must** 4009 High Point Road 21042 United States "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 Divorced 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
77 is marked other than traumatic event, the Me  $\overset{\text{Elementary/Secondary }(0-12)}{11}$ College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nelson McDonald Edna Linton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband Department of Health a Important: If item 27 is any injury or other trac Page 1 and 2 John B. Cunningham, 4009 High Point Road Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crest Lawn Mem. Grdn. 11/29/12 Marriottsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Shew 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Ener or denying Cause (Disease or injury Due to (or as a consequence of) and I-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as IE FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown RESPIRATING FAILURE CHRONIC Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform or Attending Physician: The certificate FAILURE 1 Yes 2 No \_ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 4 Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Investigation filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) D50303 12

10 State

Registrar

Rollin

Ste 205 Cotonsville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fernand

516 N.

egistrar's Signature

Chelsea Ann Combes 12-08827 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK-UN**K State of Maryland / Department of Health and Mental Hygiene 2012 40404 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day Year November 20, 2012 Medical Examiner 1500 hrs Chelsea Ann Combes 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death University Hospital Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Months Foreian Director 517-27-7028 18 Country) Montana 2 X | F 09/04/1994 1 M Usual Residence of Decedent iny 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Anne Arundel MD Yes 2 X No Severn hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7884 Chalice Road 21144 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 2 X No Widowed 4 Divorced Yes, Give Yea Yes 2 X No specify: White Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: Witem 27 is marked other than "natural",
injury or other traumatic event, the Medical Essenine; Specify. ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cashier Food Service 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James Robert Combes Be Dawn Marie Conner 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Robert Combes Father 7884 Chalice Road, Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 12/03/2012 Glen Burnie, Marvland <u> Atlantic Crematory</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cole Funeral Services, P.A. 4110 Aspen Hill Rd.#100. Rockville. MD 20853 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Immediate Cause (Final disease a Multiple Injuries xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical AMENDED 23a, 27, 28a-f, per me, g937 3-13-13 sm signed by the attending physician as be detached for use as the burial -▼ UNPENDED Division of Vital Records, P.O. Box 68760, fial or Atteoding Physician: The law requires that the death certificate be-IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Yea 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has l performed? death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other ၉ 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural within 24 hours after death.

To the Fuoeral Director: A completely filled in by the fu subject pedestrian hit by car death. Pending 1 Yes 2X No fd 11-20-12 | fd 14:07 pm 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)N/B 295 south of Arundel Mills Blvd. Hanover,MD 3 Suicide Could not be (Specify) Interstate/Express Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

OCME 2006

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

and manner stated

Assistant Medical Examiner

egistrar's Signature RELLIA

30. Name and address of person who completed cause of death (tem 23a)

29b. Signature and title of certifier

Zabiullah Ali, M.D.

29d. Date signed (Month, Day, Year)

November 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 22 3:50 PM JOHN ROBERT DALY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH **BETHESDA** MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 384-70-5946 Days Hours Min. Ju (149nth 3Day, 179)67 MT **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any highy or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD CALVERT LUSBY X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1049 REDEYE ROAD 20657 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FIELD TECH MANAGER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BRIAN THOMAS DALY MARY LOUISE LUEDTKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1049 REDEYE ROAD, LUSBY, MD 20657 DAWN DALY, WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, VERDALE PARK EMATORY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-27-12 RIVERDALE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. Simmons Lane 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Carcinoma Physician hymic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 🖾 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 certificate 2 🔀 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Certificate: To 1 N Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital Records, P.O. Box 68760 No the mosphism within 24 hours after death.

To the Funeral Director: After this in the Funeral director and the funeral directors and the funeral directors.

Baltimore, Maryland 21215-0036

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Medical

29a. Certifier (Check

Registrar

YUANBIN CHEN 31. Date filed (Month, Day, Year State NOV 2 6 2012

29b. Signature and title

of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signat

10 CENTER DRIVE, BETHESDA, MARYLAND 20892 oak.

11/22/2012

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00074022

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) NOV 20

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ KATHRYN DROUBI FRANCES Month November 5:16 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Rockville 4c. County of Death Montgomery Shady Grove Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 430-94-7924 Days Hours Director 54 1 □ M 2 🕅 F Aug. 13,1958 Oklahoma or then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Derwood 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17701 Caddy Drive 20855 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 【 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Montgomery College Office Secretary 12 should be filed wit lith and Mental Hygie 27 is marked other r traumatic event, t Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Suzanne Schneider t. Page 1 end 2 should be thent of Heelth and Men rtant: If item 27 is marke ijury or other traumatic Raymond Lee Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17701 Caddy Drive, Derwood, MD 20855 Mamdouh I. Droubi (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it eny injury or o ☐ Burial 2 💢 Cremation 3 💢 Removal from State Nov 2012, Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licen 22. Name and Address of Facility DeVol Funeral Home (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ aortic Medical Due to (or as a consequence of): Examiner ardiovascular COVS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or se a consequence or) the Hospitel or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death, the Funeral Director: After this certificate has been signed by the attending physician end mpletely filled in by the funeral director: page 2 should be detached for use as the burial transit rate has been signed by the attending physician end page 2 should be detached for use as the burial transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month 5 Other (specify) Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation within 24 hours after dea To the Funeral Directon Completely filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cortifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and Me of 29c. License number 062553 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drivey Rodonilly man lord 20850 center 9901 Medical McNeil, MD 31. Date filed (Month, Day, Year) State 32 Registrar's Signature 7 Registrar

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November 20,12

FATHRVN

Physician Medica Examine Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. ٥ Baltimore, Maryland 21215-0036 á Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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_	Registrar  1. Decedent's Name	e (First Middle	- [ ast)				Cer	tificat	e of L	eatn		2. Date of D	Reg. N	lo.		Т.	T: (B ::)	_
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	4a. Facility Name (if 419 Russ							1 '		Location rsbur				c. County  Mont				
	5. Social Security No. 201-12-	umber	6. Sex	M 2 □ F	7. Age (li	n yrs. last	birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth av, Year	924	9. Birt	thplace untry)	(State or Foreig	gn
	Usual Residence of	Decedent									L	NOV 0	J, 1	. 724	FA			
	10a. State	10b. County		r w			Town or Loc herst										nside City Limit	
	10e. Street and Nur	nber				ourc	. He z B L	10f. Zi	p Code				_	Ditizen of		-		
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	17. Father's Name (i	rirst, iviladie, t	Last)				Dev1i	n		18. Moth		e (First, Middle <b>Mae</b>	, Maidei	McKe	,			
	19a. Informant's Na	ame/Relationsl	hip <i>(Typ</i> e	, Print)								l Route Numb						
	Alice C 20a. Method of Disp		in /	Spous		20h Plac	419 F			venue		11, Ga		rsbu Location				
	1 Burial 2 4 Donation	Cremation		emoval from	State	cen	netery, cren antic	natory or o	other place	*		./2012		n Bu				
	21. Signature of Fur	neral Service L	icensee					Name ai	nd Addres	s of Facili Mort	ty	Servi	ce,	p.a.				
	23a. Part 1. Enter t	the disease, or	complic	ations that o		956 e death. I		Par	k Av	enue,	<u>Gai</u>	thersb	urg,	MD	2087		roximate	_
	shock, or hear Immediate Cause ( disease or condition	Final	only one			to	Lail	w	e t	o Ti	tri	ve					rval Between et and Death	n
	resulting in death)		C a.	Due to	(or as a co	onsequer	ice of):	~ ·		· · · · · ·	7	ve						
	Sequentially list co if any, leading to im cause. Enter Under	nditions, nmediate	b.		(or as a co					ne					-			
	Cause (Disease or that initiated events	iinjury s	c.		,													
5	resulting in death) I	Last	L <sub>d</sub>	Due to	or as a co	onsequer	ice of):											
	IF FEMALE:		u.															_
	23b. Was decedent in the past 12 r 1 Yes 2 D 9 Unknown	months?	230	c. If yes, out 1  Live 4  Preg 9  Unkr	Birth 2 [ nant at tir	Fetal d	leath 3	Ectopic Other (s,		У					ite of del onth	ivery Day	Year	
	Part II. Other signif	icant condition	ons conti	ributing to d	eath but r	not result	ing in the u	nderlying	<b>ç</b> ause giv	en in Part	I.	23e. Did	tobacco	use copt	ribute to	the cal	use of death?	
	Diahet	- m	len	2 4	ibi	reg	rde	mi	a			1 🗆	Yes 2	2 ₽ No	3 🗆 Pr	obably	4 🗌 Unknov	vn
	and a	ictiv			/ /		<u>_</u> ,		_			perf	psy ormed?	/	prior to d death?	complet	ndings available ion of cause of	e
	25. Was case referre					7			26. Pla	ce of Dea	th (Check	1 \(\superset \text{Yes}\)	2 🗹 1	No	1  Yes	2 🗆	No	
		3 No	Ho				R/Outpatien			4 ⊔ N	ursing Ho	me 5 🖪 Resi	idence	6 🗌 Oth	er (Speci	fy)		
	27. Manner of Death  1 ☑ Natural 2 ☐ Accident	5 Pendir		28a. Date (Mon	of injury th, Day, Ye		Bb. Time of injury	M 2	28c. Injury work?			28d. Describe	how inju	iry occurr	ed			
	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be		of Injury - ng, etc. (S		e, farm, stre	et, factor	y, office	-		28f. Location ( City or To			er or Rur	al Rout	e Number,	
	(Check 2	Medical E	xamine	r: On the bas	is of exam	nination a	nd/or invest	igation, in	my opinio	n, death o	ccurred at	d due to the ca the time, date e, and due to th	and plac	e, and du	e to the c	ause(s)	and manner sta	ated.
	29b. Signature and	title of certifier				1	'AA		License			0, 410 000 10 11		ate signe			(ear)	ー '2
	30. Name and addre		who com	npleted caus		-	3a) (Type, P	rint)		201	R	45002	84	AVE	NU	2	20877	>
	31. Date filed (Month	h, Day, Year)		T -	egistrar's	Signature	1	1.0	,	400	(/)	ر دردے و	ر میں ر	(4)		00	0 (/	
20	NO	V 262	<b>U12</b>	Cen	w	A.	Mar	1										

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 2012 РМ Physician/ November DeStefano Albert Anthony Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number (Month, Day, Year) **Funeral** 93 052-12-1522 1 X M 2 D F Feb. 26, 1919 NY Director 10d. Inside City Limits 10c. City, Town or Location 27 is merked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Examiner must be notified at 10b. County within 72 hours efter deeth with the Meryland Director 1 ☐ Yes 2 X No Silver Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Numbe USA 3200 North Leisure World Blvd. #504 20906 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No 1 Never Married 2 Married Š White 1 Yes 2 KNo Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates. 1943-45 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Law permit. Pege 1 and 2 should be filled with.
Department of Health and Mental Hygiens.
Importent: If item 27 is merked other the eny injury or other treumetic Attorney 18. Mother's Name (First, Middle, Maiden Surname) 8 17. Father's Name (First, Middle, Last) Anna Pepe Rocco DeStefano 20906 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3200 N. Leisure World Blvd., #504, Silver Spring, MD Rose M. DeStefano/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 26, rematory or other place) Nov. 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) F22 Name and Address Collins Funeral Home Inc. 21. Signature of Funeral Service Licens MD 20901 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days Physician/ a. Hypotension disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner hours Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine el or Attending Physicien: The law requires that the deeth certificate be executed a after death.

I Director: After this certificate has been slaned by the extending absolution and actions and actions and actions and actions and actions and actions and actions and actions and actions and actions and actions and actions are actions. ettending physicien and for use es the burlar-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Box 68760 1930 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

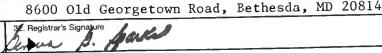
5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Day Year in the past 12 months? 1 Yes 2 No signed by the e 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospitel or Attending regions.
Within 24 hours after death.
To the Funerel Director. After this certificate has been signed in completely filled in by the funeral director, page 2 should be de Š 1 Yes 2 K No 3 Probably 4 Unknown Congestive Heart Failure, Arrhythmia Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Yes 2 No 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? of Vital To Be ALBO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔀 No 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No DESTEFANO, 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

A.

Mauro Sarmiento, MD 31. Date filed (Month, Day, Year) NOV 2 6 2012

MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

66893

11/231

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 25, PER ME C935 1/16/13 TRT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Joseph Devlin John alla Medical 4c. County of Death
Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Western MD Regional Medical Center Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **Director** 215-20-5311 1 X M 2 □ F 86 03/24/1926 Maryland Usual Residence of Deced 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland be notified at Director 1 Yes 2 No MD Allegany Cumberland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21502 Funeral 13000 McMullen Highway Examiner must "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status was Decedent Ever In U.S.
Armed Forces?
1 X Yes 2 No 1943—
If Yes, Give
Year or Dates. 1946 Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea Elementary/Secondary (0-12) College (1-4 or 5+) School Bus Contractor Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Devlin Miller Thomas Joseph Bertha ၉ 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13000 McMullen Highway, Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Print) Norma L. Devlin / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 11/27/2012 Cumberland, MD Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, of Funeral Service 21502 404 Decatur Street, Cumberland, MD Part NEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure: List only one cause on each line. Immediate Cause (Final Physician/ LMONAR disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed and -tran CERTIFICATION APPRO resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) sate has been signed by the a page 2 should be detached for g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MENINGIOMA 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes -2 X Appatient 2 ER/Outpatient 3 DOA Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Date of injury (Month, Day, 28b. Time of 28d. Describe how injury occurred Certificate: Year 5  $\square$  Pending Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely To the ! 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number NOVEMBER 27, 200 am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 12501 Willowbrook Road, Cumberland, MD William Lamm, M.D., 31. Date filed (Month, Day Registrar's Signature State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			for State Registrar	State of Ma	aryland / Dep Ce	rtificate of E		Re	eg. N 2012	40411
	Physicia Medic		Decedent's Name (First, Middle,     Norma	<sup>Last)</sup> Marie	Dawso	n		2. Date of Death		3. Time of Death 7:43 AM M
1	Examin		4a. Facility Name (if not institution, s Allegany Healt		d Rehab	4b. City, Town, or Cumbe	Location of Death		4c. County of Deat Allegan	h <b>y</b>
	Funeral Director		215-26-9914	7. Age 1	(In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birt	hplace (State or Foreign untry)
	laryland 3a-f show ified at	ector	Usual Residence of Decedent  10a. State  MD  10b. County  Alle	gany	10c. City, Town or Lo	mberland				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the M 23a or 28 ust be not	Funeral Director	10e. Street and Number 720 Furnace S	t		10f. Zip Code	21502	1	0g. Citizen of What Co USA	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Iniportant; If item 27 is marked other than "naturaly", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 💆 Divorced	12. Was Decedent E Armed Forces d 1  Yes 2 If Yes, Give Year or Dates.	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 Pes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
Baltimore, Maryland 21215-0036	ithin 72 hou ene. r than "nat the Medica	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		(Give	edent's Usual Occupa kind of work done of DO NOT use retired) K	ation during most of work	ing	16b. Kind of Business/	Industry
land 2	i be filed w fental Hygi rked other tic event, i	To Be	17. Father's Name (First, Middle, La Jesse Berry	st)			18. Mother's Nam <b>Marga</b>	ne (First, Middle, M ret Footen	daiden Surname) Berry	
, Mary	id 2 should salth and N n <b>27 is m</b> a er trauma		19a. Informant's Name/Relationshi Carolyn Barnes	(Type, Print) dau	ighter 19b. 120	adres (Street	and Number or Rur S Rd	al Route Number Ante	City or Jown, State, Zip <b>Mas</b>	ි
imore	Page 1 ar ment of He ant; If iten ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Denation 5 Other (Sp	3 ☐ Removal from State	20b. Place of Disp MD State	osition (Name of Veterans Ce	metery	Date 11/27/2012	20c. Location - City or Flintston	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lice	rensee	2	2. Name ar <b>§¢arpe</b> 108 Vi			nd, MD 21502	
- P	nysician/ Medical		23a. Part 1. Eliter the disease, or c shock, oll hilart failure. List on Immediate Caush (Final disease or condition resulting in de http	ly one cause on each line	tatic.	/2	g, such as cardiac	•		Approximate Interval Between Aget and Death
	Examiner	er	Sequentially list conditions,	b	a consequence of):					
	and L-transit	edical Examiner	if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequence of):					
760	cate be executed physician and s the burial-transit	dical	, , , , , , , , , , , , , , , , , , ,	d						
Box 687	atn certimo attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	cy		23d. Date of del Month	livery Day Year
ls, P.O.	requires that the dec been signed by the a should be detached	by	Part II. Other significant condition	s contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.		es 2 No 3 P	the cause of death?
Division of Vital Records, P.O.	ne iaw requ ite has beer oage 2 shou	Completed						24a. Was ar autops perforn 1 \(\sum \text{Yes}\) 2	y prior to oned? death?	topsy findings available completion of cause of
ital	nysician; The lavin's certificate has	Be	25. Was case referred to medical examiner?	Hospital:		_ Othe	ace of Death (Chec	k only one)		
n of V	iding Friys th. After this funeral di	cate: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigs	28a. Date of inju (Month, Day		of 28c. Injuny work	4 ✓ Nursing H y at	ome 5 LReside 28d. Describe ho	nce 6 Other (Spec w injury occurred	<u>ify)</u>
Divisio	To the Hospital of Avending Fin within 24 hours after death.  To the Funeral Director, After th completely filled in by the funeral	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determin	ot be	ıry - At home, farm, st c. (Spec <i>ify)</i>	reet, factory, office		28f. Location (Str City or Town,	reet and Number or Ru. , State)	ral Route Number,
_	e Hospir 24 hour e Funera oletely fill	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of e Nurse Practitioner: To the	xamination and/or inve	stigation, in my opinio	on, death occurred a	at the time, date and	d place, and due to the	cause(s) and manner stated.
	withii Comp	_	29b. Signature and title of certifier			29c. License			9d. Date signed (Monti	
	ne x		30. Name and address of person w	ho completed cause of d	eath (Item 23a) (Type,	Print) A	SI SI	να, Ω.	ha hadin	S015 G0216QN
	Stat Registra		31. Date filed (Manth, Day, Year)	32. Registra	ar's Signature	T TICIL	LE ST.	101 UM	100 runu 1	שטפושטיי

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 18 Physician/ November ŽÖ'12 7:30p James Wilson Dodd Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pleasant View Nursing Home Mt. Airy Carroll If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Director 578-12-6902 1 M 2 □ F March 17,1925 Maryland en "naturai", or Itema 23a or 28e-f show Wedical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filad within 72 hours efter death with the Maryland Director 1 A Yes 2 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 Prospect Road Apt 4A 21771 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ð If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 🖾 No Specify Specify: 3 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 94 Mortician/ Funeral Director Funeral Be parmit. Pege 1 and 2 should be filad Depertment of Health end Mental Hy Important: If Item 27 is marked oth any liuly or other traumatic event appe. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James W. Dodd Sr. Ruth Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah L. Dodd / Wife 106 Prospect Road, Apt. 4 A Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11/28/2012 Prospect Cemetery Mt. Airy, Maryland. 21. Signature of Fune al Service Digenses R. Name and Address of Facility tauffer Funeral Homes PMA. Airy, Maryland 21702 East Ridgeville Blvd. Mt. Airy, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner <u>Coronary Artery Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physicien and for use as the burlal-translt Cause (Disease or injury that initiated events The law requires that the death cartificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed al or Attending Phyaician: The saftar death.

Director: After this certificata i 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 Yes 2 X No ျု 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide To the Hospital or Atte within 24 hours after ded To the Funerel Director complately filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 20 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

of Vital

Division

Shakunmala Gupta MD 9650 Şantiago Road, Suite 6 Columbia, MD 21045

32. Registrar's Signature

breezeway

29c. License number

D53150

29d. Date signed (Month. Day, Year)

November 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ Month December 05, 2012 12:00M Vitalis Eileen Darr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Egle Nursing and Rehab Center Lonaconing Allegany 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 💢 F (Month, Day, Year) August 05, 1923 CountWest Virginia Days Hours 214-62-3874 89 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location Director Lonaconing 1 Yes 2 □ No Allegany Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21539 USA 57 Jackson Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural", Specify: Completed 3 XWidowed 4 ☐ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 11 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rosalie Rilev Arthur Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24100 Bartlett Run Road, Barton, Maryland, 21521 Kathleen Lee - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Data December cemetery, crematory or other place)
Cumberland Crematory 1 Burial 2 Cremation 3 Removal from State Cumberland, Maryland 05, 2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Lonaconing, MD 21539 8 East Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death EMENTIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Examin attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director. After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 126907 Hush

State Registrar

Box 68760

P.O.

Division of Vital

Bismobalsh Bood Cumberland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De	partment of Health and leartificate of Death	Mental Hygie	2012	40415
	· <del>-</del>		Registrar  1. Decedent's Name (First, Middle, Last)	stilleate of Death	2. Date of Death	i. No.	3. Time of Death
	Physicia		Jacqueline T. Edwards		November	Day 17, 2012	1845 M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1 20 13
			Ft. Washington Hospital	Ft. Washing	gton	Prince Ge	orge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	9. Birth	lace (State or Foreign
	Director		259-88-5420 59 Yrs. Usual Residence of Decedent		May 18,	1953   Geo	orgia
	ınd show at	'n	10a. State 10b. County 10c. City, Town or	ocation	_	1	0d. Inside City Limits
	faryla 8a-f tified	Director	Maryland Prince George's	Forest He	eights	:	1 X Yes 2 □ No
	the N	اق	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	
	s 232	Funeral	25 N. Huron Drive	20745		United S	tates ——
	death r item ner n		Armed Forces?	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
36	after al", o Exami	Completed by	1 Never Married 2 Married 1 Yes 2 M No If Yes, Give 1 Vear or Dates.	1 ☐ Yes 2 🗷 No Specify:			ack
ğ	hours natur lical E	lete	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	bb. Kind of Business Inc	dustry
215	in 72 e. nan "ı	duc		e kind of work done during most of wor DO NOT use retired)	king		
7	l with ygien her th	Be Co	4 P	rogram Analyst		Governm	ent
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To B	17. Father's Name (First, Middle, Last)  Inward Wilson		ne <i>(First, Middl</i> e, <i>Mai</i> Verdell F		
ar Z	nd Me marl marl			iling Address (Street and Number or Ru			Code)
Š	d 2 shalth ar			N. Huron Drive Fo			
J.e,	of Her of Her fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Discernetery, cr	position (Name of ematory or other place)	Date 20	c. Location - City or To	wn, State
Ĕ	Page ment ant: I		Bullar 2 Colemation 3 C Helloval Roll State	awn Gardens	2012	Albany, G	eorgia
Balt	ermit. nport ny inj nce.			22. Name and Address of Facility $Ste$			
_	= a o		John T. Stewart M00560	4001 Benning Road			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	1 1 2			Approximate Interval Between Onset and Death
~.	Medical		Immediate Cause (Final disease or condition resulting in death)	retastatic ad	erocar	chowd	Months
	Examiner		Due to (or as a consequence of):				
	T	ner	Sequentially list conditions, b. One to (or as a cut secular or or)				
	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events  c.				
	death certificate be executed ne attending physician and ed for use as the burial-transit	E	resulting in death) Last Due to (or as a consequence of):				
00	ate be physic the bu	dical	d				
687	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box	ath ce attend for us	cian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	ery Day Year
ų.	he de y the iched	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown				
<u>Ч</u>	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e, Did tobac	cco use contribute to the	e cause of death?
ds,	quires en sig	ted	Carcinomostosis		1 ☐ Yes	2X No 3 ☐ Prol	pably 4 🗆 Unknown
Ö	aw rec	ple	upper GIT hemormage		24a. Was an autopsy	24b. Were auto	osy findings available mpletion of cause of
Division of Vital Records,	The la	Completed by			performe	death? No 1 ☐ Yes	2 🗆 No
ā	cian: sertific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Chec	ck only one)		
_	Physical this cral dir	<u>.</u> ک	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpat  27. Manger of Death 28a. Date of injury 28b. Time	ent 3 ☐ DOA	lome 5 Residence 28d. Describe how	te 6 Other (Specify	)
0	ding th. : After : fune	cate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work?  M 1 Yes 2 No	Zod. Describe now	injury occurred	
120	Atter	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office		et and Number or Rural	Route Number,
2	tal or rs afte al Dir ed in		building, etc. (Specify)		City or Town, S	state)	
	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	ledical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check 2 Medical Examiner: On the basis of examination and/or inv				
	the lath	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	, death occurred at the time, date and pla 29c. License number		use(s) and manner as st . Date signed (Month, i	
_	¥ ≽ <b>۲</b> ۵		+ 1 1 to	Dana .	290	La La	2010
	10211		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		11-10-0	x/ (x
			11 11 - 5 - d 11/-da salan 117 011	vingston Rd #2	05 Ft. Was	shington, 6	D 20744
	Stat	e	31. Date filed (Month, Day Year) 2012 2. Registrar's Signature			) (	
	Registra	ar	MON TO COIL Sentino 10. April				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 22<sup>Day</sup> 2012<sup>Year</sup> Nov. Edith Barbara Erzen 6:00 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 01ney Montgomery Medstar Montgomery Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min 578-18-6043 **Director** 1 M 2 🔼 F 93 Dec. 7, 1918 Washington, DC Usual Residence of Decedent 28a-f show 10a. State with the Maryland must be notified at 10c. City, Town or Location Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 15310 Pine Orchard Road 20906 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian þ 1 Never Married 2 Married Black, White, ☐ Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Completed 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Supervisor Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph B. Walker, Sr. Ola Kearns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12801 Stonecrest Drive, Silver Spring, MD 20904 John E. Erzen/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Nov. 27, 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, MD 2012 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** E sque maly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at Id be detached for 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law After this certificate has performe 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita Other: ျပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending within 24 hours after death.

To the Funeral Director Af Accident 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Describing the process of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

Certifying furse Practitioner to the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature ar 29d. Date signed (Month, Day, Year) 9 20 18111 Prince Philip Drive, 30. Name and addre of person Olney, MD 20832

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Рм 7:38 James I. Elliott November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 221-05-0835 Director 1 **X** M 2 □ F 90 11/29/1921 Delaware Usual Residence of Dece 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits at **Funeral Director** must be notified 1 ☐ Yes 2 🔀 No Maryland Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? 23a United States 4111 Pinewood Terrace 20732 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten I Examiner ı Black, White, etc. þ 1 X Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: White "natural" Completed 3 X Widowed 4 □ Divorced Year or Dates. 1942-1945 of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) National Weather Service Communications Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental fitem 27 is marked of မ Mary K. McGarry John R. Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4111 Pinewood Terrace, Cesapeake Beach, MD 20732 Bruce Elliott / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 🗌 Burial 2 ី Cremation 3 🗀 Removal from State Metropolitan Crematory 11/19/2012 Alexandria, Virginia 4 Donation 5 Other (Specify) Rausch Funeral Home, P.A. 22. Name and Address of Facility 21. Signature) of Funeral Service Licenses Truc 4405 Broomes Island Road, Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ay Medical **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit Vomitine and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Surgeries has autopsy performed or Attending Physician: The after death.

Director: After this certificate h 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 TNO 4 Nursing Home 5 Residence 6 Other (Specify) ပု 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital To the Hospital within 24 hours To the Funeral D Medical 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 10 JRW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar DHMH 17 Rev 06-2011

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State

31. Date filed (Month, Day,

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Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

s Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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			Registrar			Cer	tificate of L	Death			Reg. No	201	2 4	041	9
	Physicia Medic		Decedent's Name (First, Middle, Last)     Cole	Fresho	our				2.	Date of De Month	Da	Yes Zol	1 77	ne of Death	M
	Examir	er	4a. Facility Name (if not institution, give s University of Maryla	nd Medical			4b. City, Town, or TSa Him	ore				. County of D BALTII	10RE		
	Funeral Director		5. Social Security Number 219-13-4636  Usual Residence of Decedent	7. Age	e (In yrs. last bir 30	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Bir (Month, Da )CT . 1	y, Year)		Birthplace (Si Country) INNESS		ign
	Maryland Ba-f shov	Director	10a. State 10b. County DELAWARE SUSSE	Х	10c. City, Tow BRID				•					de City Lim	
	with the	Funeral Di	10e. Street and Number 18315 ATLANTA	ROAD			10f. Zip Code 199	33		Ī	-	tizen of What ERICA	Country?		
980	s filed within 72 hours after death with the Maryland tal Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be mofflied at	≦	11. Marital Status  1 ☐ Never Married 2 ☐∰Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent E Armed Forces? 1  Yes 2 I If Yes, Give Year or Dates.			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐XNo	ispanic Origi ın, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		14. Race - Al Black, W Specify: WI	nite, etc.	ın,	
21215-0036	vithin 72 hou jiene. er than "natu the Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation e completed) College (1-4 or 5 5 +	+)	(Give I life. D	dent's Usual Occup kind of work done o O NOT use retired) ISTERED	during most o				ind of Busine	,		
and		To Be	17. Father's Name (First, Middle, Last) PATRICK ALLEN		<u> </u>			18. Mother	r's Name (Fi	irst, Middle,		Sumame)	RIDE		
Maryland	2 shoth and the and the and the transfer transfe		19a. Informant's Name/Relationship (Type CHARLES W. FRES.	e, Print)	195		ng Address (Street a	and Number	or Rural Ro	oute Numbe	er, City or	Town, State,	Zip Code)	933	
Baltimore,	Page 1 and nent of Heal ant: If item 2 ary or other		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place o	f Dispo	sition (Name of natory or other plac RY OF		Date	)	20c. Lo	ocation - City	or Town, Sta	te	
Balti	permit. Page Department Important: I eny injury o		21. Signature of Service Licensee	4	DELM	22 6	Name and Addres	ss of Facility KING	WATS	SON-Y	ZATE SEAF	S FUN	ERAL E. 19	HOME 973	3
F	nysician/ Medical	0 1	23a. Part 1. Enter the diseas or complishock, or heart (ailure List only one Immediate Cause (Finat disease or condition resulting in death)	/ Pulm			er the mode of dying Embolish		ardiac or re	spiratory ar	rest,			kimate I Between and Death	
***************************************	Examiner	ner	Sequentially list conditions, if any, leading to immediate		consequence										
	executed ien end urial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):							-		- 1
8760	certificate be inding physic use as the bu	Medica	IF FEMALE:	-									<u></u>		
		Physician/Medica	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	c. If yes, outcome of 1 Live Birth 14 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnanc Other (specify)	ey				23d. Date of Month	delivery Day	Year	
ds, P.O.	The law requires that the death ate has been signed by the atte page 2 should be detached for	þ	Part II. Other significant conditions con	tributing to death be	ut not resulting i	in the u	nderlying cause giv	ren in Part I.				use contribute			own
Vital Records,	The law rec ate has bee page 2 sho	Completed							_	24a. Was autoj perfo	psy ormed?	prior t death	autopsy findi o completion ? /es 2 🔀 No	of cause o	ole of
夏	cien: ertific ector,	Be (	25. Was case referred to medical examiner?	ospital:				ace of Death	(Check onl						
Ξ [	Physi this o ral dir	<u>و</u>	1 ☐ Yes 2 🔀 No	1 Inpatie	ent 2 ER/Ou	rtpatien		4 ∐ Nurs				Other (Sp	ecify)		
VISION OT	ttending death. stor: After y the fune	Certificate:	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day,	Year) i	njury	M 1 □	γaτ ? Yes 2 □ N	No	. Describe h					
	To the hospital or Attending Physicien: whip 24 hours after death. To the Luneral Director. After this certific. completely filled in by the funeral director,		4 ☐ Homicide determined  29a. Certifier 1 ☐ Certifying Physic	building, etc.	(Specify)			data and a		City or Tow	vn, State)			vumber,	
	io the Hos vithin 24 h o the Fur completely	Medical	(Check only one) 3 Certifying Nurse  29b. Signature and title of certifier	r: On the basis of ex	amination and/o	r invest	igation, in my opinio	n, death occ he time, date	urred at the	time, date a and due to t	nd place he cause	and due to the	e cause(s) ar r as stated.		tated.
D			30 Name and address of possess who are	ce, Mi	anth (Itam 33c) (	Time P	RES-0	00			11/	127/4	Z		
	210		30. Name and address of person who core of the second of t	rell	22	S.	Greene	St	Balt	h'more	M	D Z	1001		
	Stat Registra	е	NOV 27 201	32 Registrar	s Signatur	100	we								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State / Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11718/2012 6:40 а м AMANDA VIOLA FOREMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Asbury Nursing Home Montgomery Gaithersburg
If Under 1 Year 1 If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Days Hours 6/1071919° Virginia **Director** Yrs <del>227-22-6477</del> 93 Usual Residence of Decedent show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Gaithersburg MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** USA 20877 301 Russell Avenue Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Completed 3 XWidowed 4 Divorced Year or Dates Black permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

MCPS (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maggie Lee Hobart McKinley Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1309 Nome Street, Capitol Heights, MD 20743 19a. Informant's Name/Relationship (Type, Print) Manolia J. Daniels/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 11/26/2012 Silver Spring, MD Gate of Heaven 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home Signature of Funeral Service Licensee 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examin tansit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 🗌 No Completed Were autopsy findings available prior to completion of cause of death? ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 □No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Mann of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Medical Certificate: 1 Natural 5 Pending

Box 68760 P.O. To the Hospital or Attending Physician: The law requires twithin 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, Division of Vital

	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)			(Street and Number or Rural Route Number, wn, State)
Ī	(Check 2 Medical Examine)	an: To the best of my knowledge, death occur r: On the basis of examination and/or investigatio Practioner: To the best of my knowledge, death	n, in my opinion, death occurred	at the time, date	and place, and due to the cause(s) and manner stated
ſ	29b. Signature and title of certifier		29c, License number		29d. Date signed (Month, Day, Year)
l	I. Robert b	isaber lus	1304115		November 18,2012
		pleted cause of death (Item 23e) (Type, Print)	201 RUSSE CAITHERS	BURG.	VENUE 20877

State Registrar

DHMH 17 Rev 7/2009

pares

IN ROBERT DIRSCHOACH, WIN

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of

31. Date filed (Month, Day, Year)

26

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760

P.O.

Records,

**Division of Vital** 

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 7/2009

Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

			For State Registrar	State of Mar	yland /	Certificate of			Reg. No.	40423
	Physicia		Decedent's Name (First, Middle, La.	Stella Newma	ın Freed	d		2. Date of Dea Month	Day Yes	
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death		4c. County of D	eath
			FRANKLIN SQUE 5. Social Security Number 6. S	are Ho:	SPLTO		5 5 - 20 (2)     If Under 24 Hrs.	R Date of Birth	Balt	Birthplace (State or Foreign
-	Funeral Director		231-28-1855	□ M 2 <b>M</b> F	85 85	Yrs. Months Days	Hours Min.	8. Date of Birth (MO) 19 Day 04/02/1	927	Virginia
	yland how		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, To	wn or Location				10d. Inside City Limits
	he Mar 28a-f sl	Director	MD				Baltimore			1 ØYes 2 □ No
· ·	ath with the 23a or 2	ral Dir	10e. Street and Number 5423 Bucknell Road			10f. Zip Code	21206		10g. Citizen of What	-
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Eventine must be notified at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🍇 No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc.  White
15-C	"natu	lete	15. Decedent's Ec (Specify only highest gra	lucation ide completed)	16	Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of workin	9	16b. Kind of Busine	ss/Industry
2121	d withir giene. r than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+) 4		Trust			Ban	king
S dr	be filectal Hydrau Hydrau d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	•		
<u> </u>	d Men marke matic	မ	S10 19a. Informant's Name/Relationship (	dney R. Spence		9b. Mailing Address (Street	and Mountain on Boom		E. Burton	a Tin Cada)
Ma	nd 2 sl alth an 27 Is i		Louis Freed/Husband	type. Film.)	'	5423 Bucknell				e, 21p 000e)
$F_{r}e_{ed}$ S7 Baltimore, Maryland	ges 1 a to 1 He to 1 He to 1 He m		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemovai from State		of Disposition (Name of tery, crematory or other pla		ate	20c. Location - City	
点量	nit. Pa artmer ortant: Injury		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	1	Faii	rview Lawn Cemer		1/24/12	Onar	cock, VA
B	permi Depar Impor any Ir		John J. Willan			Williams	Funeral Home	P.O. Box	c 218, Onanco	ck, VA 23417
	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	sis		ng, such as cardiac o	r respiratory an	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or s a c		e of):				
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a c		e of):				
	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Pneu						4
68760,	eath certificate be executed attending physician and for use as the burial-trans.t	edical E		d		,				
			IF FEMALE:	23c. If yes, outcome of	prognancia					
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ 1√10 9 □ Unknown	1 Live birth 2 4 Pregnant at tii	Fetal dea		ey		23d. Date of Month	delivery Day Year
JS, F	+ W C	þ	Part II. Other significant conditions of	ontributing to death but r	not resulting	in the underlying cause given	en in Part I.			e to the cause of death?
cor	w requi	leted		· · · · · · · · · · · · · · · · · · ·				24a. Was a	240	<u> </u>
I Re	The la	Completed						autop perfor 1 ☐ Yes	rmed?   death	e autopsy findings available to completion of cause of n? /es 2 □ No
Vita	s <b>ician</b> ; certifii rector,	Be	25. Was case referred to medical examiner?	Hospital:	. =	Outpatient 3 DOA Oth	26. Place of Death	, ,	,	
of	g Phy: er this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day, Y		b. Time of 28c. Inju	ry at 2		dence 6 Other (5	Specify)
ion	ending sath. or: Aft he fun	atio	1	1			k?  Yes 2□No			
Divis	afor Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e, Place of Injury building, etc. (	- At home, (Specify)	farm, street, factory, office	2	8f. Location (S City or Tow	Street and Number of vn, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical C			xamination	dge, death occurred at the t and/or investigation, in my				
	To the vithin To the compl	Me	29b. Signature and title of certifler	( )		29c. Licens			29d. Date signed (M	***
	CA		1 dm	1	- 1	FIRT DOG	14454	r	11/20/	12
	A.		30. Name and address of person who	•		a) (Type, Print) ar 9000 FRA	nklin Sm.	- A- NO	13 c.1+0	md 21237
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature			ICEL TO DE	, , , , , , , , , , , , , , , , , , , ,	
	Registra	ar	NUV 2 6	2012 Kener	un ,	b. pares				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Month **Physician** Futyma 23, 7:45 P M Josephine Nov. Doris /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert 1600 Emmanuel Church Road Huntingtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 22, 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Year. Hours Months Days 1929 Alabama 83 412-38-5357 Oct. Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, The Modical Eventines must be notified at Calvert Huntingtown Maryland 1 ☐ Yes 2 XXVo Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 20639 U.S.A. 1600 Emmanuel Church Road Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc 72 hours after 1 ☐ Yes 2 ▼ No If Yes, Give X Year or Dates: 1 Never Married AMMarried Maryland 21215-0036 1 ☐ Yes 2**X** No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Entertainment 12 +4 Lariould be filt. Ith and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Durham Elrod Albert ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s. Department of Health ar Important: If item 27 Is. any injury or other fram 1600 Emmanuel Church Rd, Huntingtown, MD Futyma - Husband Edward Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 28 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2012 Clinton, Maryland Lee Crematory 4 ☐ Donation 15 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Ergler 20736 8200 Jennifer Lane, Owings, MD Amanda M. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NAOUR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Obacco if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 Nes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 💢 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 □Yes 2 □No thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my calculated the state of the cause (s) and manner as stated. 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 5 70 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

JRW)

State Registrar

Kaymon

31. Date filed (Month, Day,

KriNce

38

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Noble

WID

32. Registra Signature

	Please Type or Prir						
	1 _ State	aryland / Depai	rtment of F rificate of D			0010	ևու25
	1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)	Cert	incate or L	Catil	2. Date of Death	3. No. 2	3. Time of Death
Physician/ Medical	Lawrence Thomas	Guyot, Jr			NOVEMBER	23, 2012	7:45 A.M
Examiner	4a. Facility Name (if not institution, give street and number)  4021 – 36th Street			Location of Death Rainier		4c. County of Deat <b>Prince</b>	
Funeral	5. Social Security Number 6. Sex 7. Age	(m. )	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	g. Biri	thplace (State or Foreign untry)
Director	427-70-0638 Usual Residence of Decedent	73 Yrs.	Worth's Days	Tiours Iviii.		1939 Mis	3,
land f show d at	10a. State 10b. County	10c. City, Town or Loca					10d. Inside City Limits
e Mary r 28a-t notifie	District of Columbia  10e. Street and Number	Washi	ngton 10f. Zip Code		10	g. Citizen of What Co	1 X Yes 2 No
leath with the Maryland items 23a or 28a-f sho er must be notified at Funeral Director	507 "U" Street, N. W.		2000	)1		Inited Sta	-
	11. Marital Status 12. Was Decedent E- Armed Forces?	If '	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
s after al", or Exami	1 ☐ Never Married 2 【X Married 1 ☐ Yes, 2 X I 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates.	No 1	☐ Yes 2 X No	Specify:			lack
onthin 72 hours after cleine.  r than "natural", or the Medical Examin	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupa nd of work done o	ation during most of work	ina	6b. Kind of Business	
ithin 7, ene.	Elementary/Secondary (0-12)  College (1-4 or 5-6+ years	life. DO	NOT use retired)			Government t District	t of the t of Columbia
filed wal Hyging dother went, in Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma.	iden Surname)	
permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.  To Be Complete	Lawrence Thomas Guyot,			Margar			
12 sho llth and 27 is r r traur	19a. Informant's Name/Relationship (Type, Print)  Monica Regina Klein Guyot	(Wife) 507				ity or Town, State, Zij	
of Head of Head of Item	20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State	20b. Place of Disposi	-			Oc. Location - City or	
t. Page tment rant: I	4 ☐ Donation 5 ☐ Other (Specify)	Chesapeak	e Cremat	ory, Inc.	В	eltsville,	
permi Depar Impo any ir	21. Signature of Funeral Service Licensee						Morticians, on,D.C.20011
Physician/ Medical Examiner xaminer	Sequentially list conditions, b.		discas		or respiratory arrest		Approximate Interval Between Onset and Death
	that initiated events C.	consequence of):					
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial Medical Certificate: To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 🗌 Fetal death 3 🔲	Ectopic pregnanc Other (specify)	y		23d. Date of de Month	livery Day Year
requires that the dec been signed by the should be detached	Part II. Other significant conditions contributing to death but	ut not resulting in the un	derlying cause giv	ven in Part I.			o the cause of death?
The law require cate has been signate has been signated by page 2 should be completed.				<del> </del>	24a. Was an autopsy performe	24b. Were au prior to death?	utopsy findings available completion of cause of
ician: The certificate rector, pag	25. Was case referred to medical examiner?			ace of Death (Chec	k only one)		
Physi r this o eral din	27. Manner of Death 28a. Date of injur	ent 2 ER/Outpatient  y 28b. Time of	28c. Injun	v at	ome 5 Residen		Son's Home
arh. rr: Afte ne fune	1 X Natural 5 Pending (Month, Day 2 Accident Investigation	(Year) injury	work	? Yes 2 🗌 No		, ,	
tal or Attending Fra after death.  al Director: After teld in by the funer.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stree . (Specify)	et, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, Medical Certificate: To Be C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of a 2 Medical Examiner: On the basis of examiner on the basis of examiner. To the	kamination and/or investig	gation, in my opinio death occurred at t	on, death occurred a he time, date and pl	t the time, date and ace, and due to the	place, and due to the cause(s) and manner a	cause(s) and manner stated as stated.
To cor	29b. Signature and title of certifier  Maren Mayheus	CRUP	29c. License	5729	3 No	ovember 3	
Jin Jin	30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Pr				Suite 180	
State		ır's Signatule	Largo	, Marylan	<u>ad 20774</u>		
Registrar	BER D A BREA	Bo page	P. Carlo				
HMH 17 Rev 06-2011	his make a to he are see and						

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 77/79\5075 Physician/ GURGANIOUS 10:10 P M JAMES н. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Camp Springs 4c. County of Death Prince George's Examiner 6426 White Oak Avenue If Under 1 Year If Under 24 Hrs ocial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 241-44-8322 Days Hours Director 1**X** M 2 □ F 79 06/53/7433 NC Usual Residence of Deceden 28a-f show 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director MD Camp Springs Prince Georges 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 AZU 6426 White Oak Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. b 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates 2 No Baltimore, Maryland 21215-0036 nan "natural", Medical Exan Specify: Black 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Medical Facility Administrator the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hilda Corbett James E. Gurganious 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 6426 White Oak Ave., Camp Springs, MD 20748 James H. Gurganious, Jr. / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cheltenham, MD MD Veterans Cemetery 77/59/5075 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Likens 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 . Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Gastrointestinal Stromal Tumor Physician/ disease or condition resulting in death) 7 years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 1 Yes 2 No Month Year Pregnant at time of death Day ed by the a detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 perform 2 X No Yes 2 X No 1 Yes Be

Box 68760 P.0. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica of Vital funeral To the Funeral Director: After completely filled in by the funer Division

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

064234

only one

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

191

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Wana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Nicholas DeMonaco, 8926 Woodyard Rd., AlOl, Clinton, MD 20735

State Registrar

၉

Certificate:

Medical

31. Date filed (Month, Day, Year) NOV 2 8 2012

35m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40427 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 17, 2012 Physician/ Albert Nei1 5:55 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heart Home Assisted Living Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Director 579-36-7369 1 🗚 M 2 🗆 F 85 Yrs Feb. 6, 1927 Washington, DC Usual Residence of Decedent permit. Paga 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Importent: If Item 27 is merked other then "naturel", or Itsms 23a or 28a-f show eny Injury or other trsumetic event, the Medical Evaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3023 Arundel on the Bay Road 21403 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>چ</u> 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cartographer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Gray Alice O'Neill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Neil Gray/Son 503 Tayman Drive, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Nov. 21 2012 1 Burial 2 Cremation 3 Removal from State Importent: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Sp#cify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Mates Kerberd L 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiac Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attanding physician end I for usa es tha buriek transit Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav ate has bean signed by tha a paga 2 should be datachad Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Atrial Fibrillation, Hyperlipidemia, Type II Diabetes Completed 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has performed?
Yes 2 A No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifical complately filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specific) 1 ☐ Yes 2 🖾 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred To tha Hospital or Attending I within 24 hours aftar daath.
To the Funeral Director: After 1 X Natural 5 Pending ☐ Accident Investigation □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 31. Date filed (Month, Day, Year)

NOV

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

ANDREW MCGLONE, MD 2002 MEDICAL PARTURY SUITE #670 AMMARIS, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0062349

29d. Date signed (Month, Day, Year)

NOVEMBER 19TH 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 40428 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 2012 Batool Ghazizadeh November 12:54 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Hours 218-23-0942 **Director** 1 M 2 X F Iran 09/01/1933 ms 23a or 28a-f show must be notified at Director 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Montgomery Rockville 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14401 Traville Garden Circle Apt.413 20850 USA "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 X Married 21215-0036 72 hours after 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: White Completed 12 should be filed within 72 hours a alth and Mental Hygiene.
127 is marked other than "natural or traumatic event, the Medical Es Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Home Maker Own Home Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Abdol Hossein Ghazizadeh Sedigheh Vahedi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20850 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Esmail Jalali Husband 14401 Traville Garden Circle, Apt. 413 Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park11/25/2012 Rockville, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Cole Funeral Services, P.A. 4110 Aspen Hill Rd.#100, Rockville, MD 20853 23a. Part 1. Enter the disea complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between shock, or heart failure. L Immediate Cause (Final Onset and Death Physician/ Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown 3 Ectopic pregnancy 4 ☐ Pregnant 9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1  $\square$  Yes 2  $\overline{\mathbf{X}}$  No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 1 Yes 2 No Vital Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) o 27. Manner of Death 28b. Time of 28c. Injury at To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending 1 X Natural work? Division Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D0063195 November 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 8600 Old Georgetown Road, Bethesda, Maryland 20814 Steven Wilks, M.D.

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 26

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 26, 2012 SUE GIBSON 2:04P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 5, 1951 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 367-54-7707 Michigan 1 □ M 2 1 F Director 61 ms 23a or 28a-f shov must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Prince George's Beltsville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11606 35th Place 20705 United States 2 should be filed within 72 hours after death w th and Mental Hygiene. 27 is marked other than "natural", or Items traumatic event, the Medical Examiner my 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Douglas Raymond Soeder Dorothy Elaine Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine Bethea -Companion 11606 35th Place Beltsville, Maryland 20705 1 and 2 s f Health a item 27 i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot cemetery, crematory or other place)
Metropolitan Crematory 11/30/2012 1 Burial 2 KCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Bohard V: Borgwardt Funeral Home, PA Dona 4400 Powder Mill Road Beltsville, Maryland 20705 ngua 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Severe Disseminated Intravascular Coaculation disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner <u>Septic Shock</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exami attending physician and for use as the burial-transif Hypovolemic Shock Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 N No
9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) Month Year cate has been signed by the a page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a Was an this certificate has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director; After this certificate h completely filled in by the funeral director, **Division of Vital** 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Yes 2 🔀 No 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 14 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date, signed (Month, Day, Year) M1) 11/27 D 00 16063 ess of person who completed cause of death (Item 23a) (Type, Print)

70

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signal

32. Registrar's Signature

Noeraj Mendiratta, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40430 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Dexter GILES HARLOW JR 2012 11:54 A Medical 4a. Facility Name (if not institution, give street and number WALTER REED 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL MILITARY MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) May 13, 1932 Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 472-30-9711 Days 1 X M 2 □ F **Director** 80 Minnesota Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo VA Fairfax McLean 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6831 Fairway Drive 22101 U.S.A hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Mamed 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1957-1987 Year or Dates. 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 at Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Colonel (Pilot) USAF Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file nd Mental H marked o Giles Dexter Harlow Ella Johnson other traumatic 1 and 2 should b of Health and Mei fitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Q. Harlow/Spouse 6831 Fairway Dr., McLean, VA 22101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 ō ō 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Nov. 24, 2012 Falls Church, VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Maripat Putnam Kline/ May Murphy Funeral Home, 4510 Wilson Blvd., Arl, VA 22203 Une 23a. Part 1. Enter the disease, or complications that/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PARKINSON'S DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed and I-tran resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 1 Yes 2 No signed by the a d be detached f 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Records, cate has been sig ', page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 X No 잍 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural 2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0101252357 NOV 20 2012 23M aperson who completed cause of death (Item 23a) (Type, Print)WALTER REED NATIONAL MILITARY MEDICAL CENTER GEOFFREY A. LOH, BETHESDA, MD 20889 31. Date filed (Month, Day, Year) NOV 2 6 2012 2. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mar				1ental Hyo	giene	
			State Registrar	Cer	tificate of D	eath		Reg. No. 2	012 40432
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	Medic	al		ckey			Novembe		
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or				ty of Death
	Funeral		Wilson Health Care Center 5. Social Security Number 6. Sex 7. Age (1)	n yrs. last birthday)	Gaithe If Under 1 Year	rsburg If Under 24 Hrs.	8. Date of Birt		9. Birthplace (State or Foreign
	Director		176-26-0967 1□M2⊠F	Yrs.	Months Days	Hours Min.	(Month, Day	, Year)	Country)
	» »		Usual Residence of Decedent  10a. State 10b. County 1	77			10/27/	1935	Pennsylvania
	ryland -f sh	ctor		0c. City, Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	e Ma r 28a notifi	Dire	Maryland Montgomery  10e. Street and Number	Olney	10f. Zip Code			10 011	
	vith th	Funeral Director							f What Country?
	ems	nne	3517 Toddsbury Lane  11. Marital Status  12. Was Decedent Eve	r in U.S. 13. W	20832 Vas Decedent of His		cify Yes or No-		ace - American Indian,
ဖွ	ter de , or it	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No		Yes, specify Cuban		Rican, etc.)	Bla	ack, White, etc.
8	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	ted	3 ☐ Widowed 4 🔀 Divorced If Yes, Give Year or Dates.	1	Yes 2 X No	Specity:		Specif	<sup>fy:</sup> White
<u>5</u>	72 ho "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done du		ng	16b. Kind of	Business/Industry
7	ithin ene. thar	Con	Elementary/Secondary (0-12) College (1-4 or 5+)		NOT use retired)			Montgor	mery Co. Schools
р 2	led w Hygi other	Be	17. Father's Name (First, Middle, Last)	1 1701	ary hide	18. Mother's Name			
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ary	should and N is ma	170	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street ar	nd Number or Rura	l Route Number	City or Town,	State, Zip Code)
Σ	and 2 s Health s tem 27 other tra		Linda A. Hickey/Daugnter	3517	Coddsbury	Lane, 0	Lney, Ma	ryland	20832
ore	tof Hall of Hall of other or o		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of atory or other place	) [	Date	20c. Location	n - City or Town, State
Baltimore, Maryland 21215-0036	t. Pag tmen tant: ijury		4 Donation 5 Other (Specify)						Pennsylvania
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Simplure of Funeral Service Licensee	/ 1/	Name and Address				
ı			23a. Part 1. Enter the disease, or complications that caused th						arg, MD. 20877 Approximate
	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	CODD					Interval Between Onset and Death
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transition.	edical	29a. Certifier (Check						
	thin 2 thin 2 the F	Me	only one) 3 Certifying Nurse Practitioner: To the b		death occurred at th	e time, date and pla	ce, and due to the	ne cause(s) and	manner as stated.
	P S D WH		29b. Signature and title of certifier		29c. License				ed (Month, Day, Year)
	4		30. Name and address of person who completed cause of deat	h (Itom 22a) (Fire B		5301		Novemb	per 23, 2012
			Farzana Ajmal, M.D., 18509 K			mantown	Marvla	nd 2087	'4
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	Registra	ır	31. Date filed (Month, Day, Year)  NOV 2 7 2012	Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nov. 17, 2012 Rodrigo 2310 Alvaro Herrera Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1072 Pay Year 76 Mexico Director 36 none 1X M 2 | F Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notifled at 10d. Inside City Limits Director MD Prince George' New Carrollton 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8008 Powhatan Street 20784 Mexico 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 🙀 No If Yes, Give 1⋤Yes 2□No Specify: Mexican Maryland 21215-0036 White 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction 6 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Magdaleno Vivar Cruz Marciana Herrera Espinoza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 Janet Sosa/Wife 8008 Powhatan Street New Carrollton, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Guadalupe, Santa Ana 12/3<sup>D</sup><sup>#</sup>2012 1 🏝 Burial 2 🔲 Cremation 3 🔀 Removal from State Panteon Armando San Isidro Jehuital 4 Donation 5 Other (Specify) 21. Signature of Faneral Gervice License Puebla, Mexico PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart finiture. List only one cause on each line. Approximate Interval Between 4 MO Immediate Cause (Final Physician/ disease or condition resulting in death) Gastric Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No ☐ Yes 2 No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a d title of certifier 29d. Date signed (Month, Day, Year, D33224 Nov.19,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ram Trehan M.D 1500 Forest Glen Rd. Silver Spring, Md 31. Date filed (Month, Day, Year) Registrar's Signature

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State

Registrar

Box 68760

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Division of Vital Records.

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service L	icensee Anni	46	Fr	Name and Address J.	ess of Facility Collins	Funeral	l Hon	ne Inc		
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To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s	Medical	(Check 2		Physician: To the best kaminer: On the basis o Nurse Practioner: To t	f examination	and/or invest	igation, in my opinio	on, death occurred	at the time, date	and place	and due to	the caus	se(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ John Calvert Holland, Sr. 2012 Nov 8:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 3090 Hunting Creek Road Huntingtown Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) Director 218-38-6903 1 🗓 M 2 □ F 71 06/09/1941 MDUsual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be notified at Director Calvert 1 Yes 2 No Huntingtown MD 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3090 Hunting Creek Road 20639 USA ral", or items 23 Examiner must within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces 7
1 Yes 2 ANo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Black, White, etc. þ 1 Never Married 2 Married 2 should be filed within 72 hours after the and Mental Hygiene.
27 is marked other than "natural", or Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Sub-Contractor (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Masonry 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Richard Holland Virginia Brooks Helen permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trudy Spriggs/Daughter 2335 Al John Way Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Ches.High.Mem.Gar 12/4/2012 Port Republic, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell F 1451 Dares Beach Rd. 21. Signature of Funeral Service License Funeral Home, P.A. Prince Fred.,MD20678 Thad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause qui each line Immediate Cause (Final Onset and Death PhysicianV disease or condition resulting in death) 50 Medical Due to (or as a consequence of) Examiner Sequentially liet conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death 2 No ed by the a 1 Yes 2 Unknown Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an burs after death.

eral Director: After this certificate has I filled in by the funeral director, page 2.8 autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hou To the Fune completely fi (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year

State Registrar

barke

Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

Jonathan Lowenthal, M.D.

NOV 28

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $N_{\scriptsize{OV}}^{\scriptsize{Month}}$ 2012 Harrison 19. 7:00 Elizabeth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7625 B Street Calvert Chesapeake Beach 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Director 229-26-2036 1 □ M 2 🗓 F 84 Virginia Dec.21,1927 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mechanicsville St. Mary's Maryland 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 20659 Golden Beach Road U.S.A. 39072 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes 2 ☐ No If Yes, Give XX Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Costello Charles Milton Florence Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39072 Golden Beach Rd, Mechanicsville, MD 20659 - Husband Bradley Harrison 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee Crematory Date 23, 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Nov. 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Gof 8200 Jemnifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) a ATRIAL FIBRILLATION month Medical Due to (or as a consequence of): Examiner DISEASE ORONAR Sequentially list conditions, if any course to include cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Year after death.

Director: After this certificate has been signed by the sd in by the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALZHEIMER'S DEMENTIA Completed 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of CONCESTIVE 24a. Was an autopsy performe 1 ☐ Yes 2XX No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Parle bate, r's Residence ျှ 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours aft

To the Funeral Discompletely filled in Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in rify opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MD 29d, Date signed (Month, Day, Year) 20/2 ATmena D001942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dew MD 20678 PRINCE FREDERICK 130 Hasp RD MD MUNIMI 31. Date filed (Month, Day, Year) 32. Registrar Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Evelyn Louise Hallowell 20:05pM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Atlantic General Hospital Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 215-34-1820 Director 1 □ M 2 🏻 F 7-20-1937 Baltimore, MD Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester 1 XYes 2 No Berlin 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r Funeral 26 Heron Isle Court 21811 USA items 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify White Completed 3 Widowed 4 Divorced Specify the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Town of O.C. Travel of Health and Mental Hygie If item 27 is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Arthur Lindsay Phoebus Jennie Hughes other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Hallowell - Son 93 Ocelot Dr. Hanover, PA. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ŏ Important: I any injury or Cedar Hill Com. Glen Burnie, MD. 4 Donation 5 D ther (Specify) 11-24-12 22. Name and Address of Facility The Burbage Funeral Home Service License William St.Berlin, MD. 21811 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Records, P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD, severe pulmonary hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No Hallowe 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 🕳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signato 29d. Date signed (Month, Day, Year)
November 19, 2012 D56307 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Healthway Drive, Berlin, MD 21811 Registrar's Signature Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ELLA JEAN HOLLAND 2012 November 1:40 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 26400 Asbury Avenue Crisfield Somerset Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 1 M 2 X F 90 <u>215–36–1868</u> Sept. 22,1922 Maryland ir than "netural", or items 23a or 28a-f show the Wedleal Examinar must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Crisfield 1 Yes 2 XNo Maryland Somerset 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21817 USA 26400 Asbury Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Š 1 ☐ Yes 2 X No If Yes, Give ould be filed within 72 hours after and Mental Hygiene. merked other than "netural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 🗓 Widowed 4 🗋 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Paintbrush Manufacturer</u> Assembly Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ Charles Landon Henrietta Marshall and le 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s of Health item 27 Sylvia Cullen (Daughter) 27084 Gillette Drive - Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 e
Department of H
Importent: If ite
any Injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Sunnyridge Memorial Park 11/26/2012 Crisfield, Maryland 21. Signature of Funeral Service Licensee

Mary Beth Bradshaw-Pruit 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ASCVI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): anding physician and use as the buriel-transit The law requires that the death certificate be executed Cause (Disease of injuly that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month 5 Other (specify) Day Year ned by the at 9 detached fo 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 8 Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed After this certificate 1 ☐ Yes 2 ☐ No 2 🛭 Physician: completely filled in by the funeral director, of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death ie Hospitel or Attending Pl n 24 hours after death. ie Funeral Director: After th Certificate: 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Division Investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D48098 Nov. 26, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. 201 Hall Highway - Crisfield, MD 21817

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 6 2012

32. Registrar's Signature

12-08716 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Vincent Charles Healy, Jr. 2012 40439 Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death **Medical Examiner** 1931 hrs Vincent Charles Healy Jr. November 16, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Director Days Hours Min 1X M Country Maryland 212-33-8881 2 Yrs 4/20/1991 Usual Residence of Decedent any. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No , or items 23a or 28a-f show r must be notified at ooce. caltimore, MD 21215-0036

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importator: If item 27 is marked other when the contraction of the cont Thurmont Frederick Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13618 Tower Road 21788 United States Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White Specify Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Electrician Electric 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Vincent Charles Healy Sr. Dixie Lee Schildwachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent C. Healy Sr. 13618 Tower Road, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify Garfield U. M. Cemete**t**y11/21/12 Smithsburg, Maryland <sup>22</sup> Name and Address of Facility Stauffer Funeral Homes P. A. 104 East Main Street, Thurmont, MD 21788 21. Signature of Funeral Service Licens Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) After this certificate has been signed by the atte funeral director, page 2 should be detached for i 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> DOA Nursing Home 5 Residence 6 Other: 2 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Nov 16, 2012 Operator of motorcycle involved in collision 1 Natural 1827 hrs 1 Yes 2 ✔ No Pendina To the Fuoeral Director: completely filled in by the 2 🗹 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Rt. 77 W/B at Pleasant Valley Road, Thurmont, MD determined (Specify) Local Street 4 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 17, 2012

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State Registrar

ORIGINAL

Assistant Medical Examiner

32. Registrar's Signature

900 W. Baltimore Street, Baltimore, MD 21223

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Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20°1°2 Joyce Pullen Ireland November 10:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday) Funeral Davs Hours 220-26-6957 Director 1 □ M 2 🕏 F 10/30/1921 91 Texas Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 A No Maryland | Calvert Lusby 10f. Zip Code 10e. Street and Number ö 10g. Citizen of What Country? must be Funeral 23a 20657 United States 13437 Olivet Road permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itemany injury or other traumatic. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🐼 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 k No Specify. If Yes Give Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) US Government Administrative Assitant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Florence Parlier Homer Pullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13430 Olivet Road, Lusby, MD 20657 Kevin R. Dove / Nephew altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/27/2012 Metropolitan Crematory Alexandria, Virginia Rausch Funeral Home, P.A. once, Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Kalama Onset and Death Immediate Cause (Final Ph<sub>sician</sub>/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Sequentiary list conducting any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as the IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ Box in the past 12 months?
1 Yes 2 No for Day Month Vear Pregnant at time of death 9 Unknown the 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 M No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation Accident filled in by the 1 within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of D060473 2012

State Registrar Whroad

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eted cause of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40442 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ACKSON 36 AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Suitland Hand If Under 1 Year If Under 24 Hrs. Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Min. Hours (Month, Day, Year) Country) Director 1 M 2 🗆 F Yrs. -22-Nash 23a or 28a-f show 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director 1 Yes 2 No Hano 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha enera Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deparment of Health ar Important: If item 27 is any injury or other trauging. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 🗹 Burial 2 🗌 Cremation 3 🔲 Removal from State 11-29-12 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Pridgen Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Drie to for as a consequence of: physician and s the buriel-transit resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day After this certificate has been signed by the funeral director, page 2 should be deteched 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ☐ Yes 2 ☑ N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No the Investigation 3 Suicide
4 Homicide To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Houdehou, my Jucelyne D-63748 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) How den 4041 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:00 Medical Facility Name (if not institution, give street and no 4c County of Death **Examiner** 4b. City, Town, or Location of Death ton Nursing and Kehabi 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 If Under 24 Hrs. 9. Birthplace (State Country) Director 1 □ M 2 💢 F show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Completed by Funeral Director 1 Tyes 2 No 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ondary (0-12) College (1-4 or 5+) tirement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 127 is marked er traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kiema Johnson Daughter Kennebec 20745 Department of Health Important: If item 2: any injury or other tonce. other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State -2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licence 22. Name and Address of Facility Greene Funeral Home Franklin Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) -tran and that initiated events Due to (or as a consequence of) resulting in death) Last burialsigned by the attending physician To Be Completed by Physician/Medical Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💇 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗌 Yes Division of Vital funeral director, 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Matural Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. an EITM 30. Name and address of person who completed cause of death (Item 23a) (Type) Print) Ella MC 692 32. Registrar's Sigrature State 0 Registrar

DHMH 17 Rev 06-2011

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			Registrar  1. Decedent's Name (First, Middle, Last)		Ce	rtificate of L	Jeatn		eg. No.	12 40444
	Physicia	n/		Tabaaaa				2. Date of Deat Month	Day	3. Time of Death Year 7 • 3 5 Δ Μ
	Medic Examin		Robert  4a. Facility Name (if not institution, give st	Johnson reet and number)		4b. City, Town, or	Location of Dea	November	4c. County	512 7.55 A
	LAGITIII	CI	Wilson Health Care			Gaithe			1	tgomery
	Funeral		5. Social Security Number 6. Sex	7. Age (	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs			9. Birthplace (State or Foreign
	Director		062-16-9381	M 2 □ F	92 Yrs.	Months Days	Hours	0971671	920	New York
	nd how at	<u>_</u>	Usual Residence of Decedent  10a. State 10b. County	1	10c. City, Town or Lo	cation				10d. Inside City Limits
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	or 28 or 28 e noti	Dir	Maryland Montgor  10e. Street and Number	nery [	Gaither	10f. Zip Code		1	Og. Citizen of W	
	with i	Funeral Director	201 Russell Avenue			2087	77		Unite	d States
	death items ier m	Fun	11. Marital Status	2. Was Decedent Eve Armed Forces?		Was Decedent of Hi	spanic Origin? (S	Specify Yes or No-	14. Race	e - American Indian,
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Z	ld be Ment arked atic e	욘	John Ma	rtin J	ohnson			Anna	Eng_	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street a	and Number or R	ural Route Number,	City or Town, St	ate, Zip Code)
a)	and 2 Health em 2 ther t		Garret M. Johnson/ 20a. Method of Disposition	Son	1210 20b. Place of Dispo		<u>Road Ext</u>	T		York 11971
وّ	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 🖾 Cremation 3 🖾 R		cemetery, crei	natory or other plac				City or Town, State
Baltimore,	nit. Pa artme ortan injury		4 ☐ Donation 5 ☐ Other (Specify)					2//2012   Fune		ai, New York
g	permit. Page 1 a Department of H Important: If ite any injury or otl		Markey	MO. V	1 1 1					eg, MD 20877
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the						Approximate
	nysician/	10.3	Immediate Cause (Final disease or condition	Adre	etfail	meto	Misio	e		Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a c	conse (ue ce of):					
		ř	Sequentially list conditions, b	Den	rentia					
	or to	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury		tonsequende off:					
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ŏ ×	h cert tendir r use	an/I	23b. Was decedent pregnant in the past 12 months?	sc. If yes, outcome of 1 Live Birth 2		Ectopic pregnanc	у			e of delivery
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j.	ding Physician: The law requires that the death certifica h. After this certificate has been signed by the attending pl funeral director, page 2 should be detached for use as the		Part II. Other significant conditions conf	tributing to death but	not resulting in the (	inderlying cause giv	en in Part I.	23e, Did tob	acco use contri	bute to the cause of death?
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<u> </u>	requ been shoul	lete	Chatractive	urosat	ther. Box	delicio	11111	24a. Was ar	24b. W	Vere autopsy findings available
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<u>=</u>	an: T rtifical tor, p	Be C	25. Was case referred to medical	7		26. Pla	ace of Death (Che		2 🗖 No 1	Yes 2 No
Alta	nysici nis ce direc	To E	examiner? 1  Yes 2 No	ospital: 1	t 2 ER/Outpatie	nt 3 🗆 DOA Othe	er: 4 🖪 Nursing	Home 5 🗆 Reside	nce 6 🗆 Other	r (Specify)
0	ing Pt		27. Manuer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, )	28b. Time of injury	work	?	28d. Describe ho	w injury occurre	d
0	ttendi death tor: A the fi	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	00 - 51 (1-1-	All a d		Yes 2 No			
UIVISION	I or Al after Direc	Cer	4  Homicide determined	building, etc. (	- At home, farm, str Specify)	eet, factory, office		City or Town,		r or Rural Route Number,
2	spita hours neral d fillec	ical	29a. Certifier 1 Certifying Physic							
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  Within 24 hours after death.  Within 24 hours after death.  Completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the complete of the	Medical		r: On the basis of example to the be						to the cause(s) and manner stated.
	Loon Towith		29b. Signature and title of certifier		1	29c. License			_	(Month, Day, Year)
P	10		14 Dohert 20		\		4115	1/1	oven	Wer 24,2012
-			30. Name and address of person who con	npleted cause of dear	th (Item 33a) (Type, I	CALTE	USS 21	URGIN	sue 20	0847
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's	Signature for	Ked.			51.10 - 70.02 10.00	a forefere a terre of the a
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AMEND#3,23b,23e,24a/b,25,26,27,28a,30cerMD,11/27/12;BW,McO
State of Maryland / Department of Health and Mental Hygiene

1- For AMEND#9,15,16a/b,17,18,19b,20a-c,22perH,11/26/12;BW,McO
Registrar

Reg. No. 20 | 2 Reg. No. 2012 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 23-2012 **Physician** 11011 10 /Medical or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** Montgomery Nursina hasp Kehab MAC If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug 20, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) IIII **Funeral** 1 ☐ M 2 🛣 F Months 84 409-40-7258 Director West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Hvattsville MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 29078 1821 Ray Leonard Rd. Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "naturar", or items 233 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1∐Yes 2∐XNo If Yes, Give Year or Dates: Specify. ģ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Computer Programer Federal Government Yr Sunk Elementary/Secondary (0-12) -unk-18. Mother's Name (First, Middle, Maiden Surname) unle 17. Father's Name (First, Middle, Last) - unk Be James Edward Thomas Pearl Ramey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 1821 Ray Leonard Rd. Landover, Md. 20785 Anthony Johnson - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Moment Chesapeake Crematory 11/16/2012 Beltsville, Maryland 22. Name and Address of Facility of Launey's Funeral. House 21. Signature of partial Service Licensee 3831 Georgia Ave, NW Washington, 10 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) monary 040 **Physician** /Medical Due to (or as a conseque ce of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as \*\* onsequence of) Examiner e burial transit be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: for use a yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 🗆 X o 1 □Yes 2X No 1 ☐ Yes Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi Completely filled in by the funeral of funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10/24/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wwuhan Wang, M.D.--15245 Shady Grove Rd#130; Rockville, MD 31. Date filed (Month, Day, Year) State NOV 26 2012 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of M		artment of Health and			2 1011.6
		_	Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death	2. Date of Deat	Reg. No.201	
	Physicia Medic		Kempton Boyce Jenkins			11/18/2		3. Time of Death 6:41P M
	Examin		4a. Facility Name (if not institution, give street and number)  Suburban Hospital		4b. City, Town, or Location of Dea Bethesda	th	4c. County of E	
	Funeral			e (In yrs. last birthday)	If Under 1 Year If Under 24 Hr		1 9.	Birthplace (State or Foreign
	Director		323 20 1809 1 X M 2 □ F	86 yrs.	Months Days Hours Mir	06/08/		Country) Florida
	nd thow at	្ក	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	pation			10d. Inside City Limits
	Aaryla 8a-f s tified	Director	MD Montgomery	Bethesda	L			1 Yes 2 □ No
	a or 2 be no		10e. Street and Number		10f. Zip Code		10g. Citizen of What	t Country?
	ns 23 must	Funeral	4401 Tournay Road		20816		United S	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent 1  Armed Forces?  1 ▼ Yes, Give  Year or Dates. 1	No If	Vas Decedent of Hispanic Origin? (f f Yes, specify Cuban, Mexican, Pue Yes 2 🛣 No Specify:	Specify Yes or No- rto Rican, etc.)	Black, V	American Indian, Vhite, etc. White
15-0	72 hou n "natu ledica	nplet	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupation kind of work done during most of we	orking	16b. Kind of Busine	ess/Industry
12	ithin ithin riene.	Con	Elementary/Secondary (0-12) College (1-4 or 5	0+)	ONOTuse retired)  sign Service Off:	lcer	State De	pt.
d 2	illed wall Hygial Hygial I othe	Be	17. Father's Name (First, Middle, Last)	1010		ame (First, Middle, N		
ylar	ld be l Menta arked	은	Nelson Boyce Jenkins		Margai	ret Louis	e West	
, Maryland	nd 2 shou ealth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Timothy Jenkins/Son		ng Address (Street and Number or F Nonesty Way Bethe		City or Town, State 20817	, Zip Code)
Baltimore,	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	National	Crematory 111/	23/2012	20c. Location - City Falls Chu	rch, VA
Balt	permit. Departi Import any inj once.		21. Signature of Furieral Service Licensee		Name and Address of Facility J. 30 Wisconsin Ave			
	trystetun/		23a. Part 1. Enter the discrete, or complications that cause shock, or heart fail to List only one cause on each line. Immediate Cause (Final					Approximate Interval Between Onset and Death
	Medical Examiner		Renal F		rombocytopenia :	Larombost	S	Days
	ansit ansit	Examiner	cause. Enter Underlying Cause (Disease or injury  Aortic	Stenosis S/	'P Aortic Valve l	Replacemen	nt	Months
09	ate be executed physician and the burial-transit	dical Ex	that initiated events resulting in death) Last  C. Due to (or as	a consequence of):				
876	tificat ng ph		IF FEMALE:	= nk.n				
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.  To the Funeral Director, Affer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Physician/M	23b Was decedent pregnant 23c. If yes, outcome	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of Month	f delivery Day Year
s, P.O	ires that the signed by do detail	Completed by PI	Part II. Other significant conditions contributing to death by Hypertension	out not resulting in the u	nderlying cause given in Part I.	23e. Did tob		e to the cause of death?  Probably 4 Unknown
ord	v requ	olete	Diabetes			24a. Was a	n 24b. Were	e autopsy findings available
3ec	he lav tte has page 2	omi				autops perform	med? deat	to completion of cause of h? Yes 2 \( \subseteq \text{No} \)
<u>la</u>	sian: T	Be	25. Was case referred to medical examiner?		26. Place of Death (Ch			
Ž	Physic this ce	မ	1 Yes 2 No	ient 2 ER/Outpatien		Home 5 Reside		pecify)
Division of Vital Records,	lending Reath.	Certificate:	27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	y, Year) 28b. Time of injury	28c. Injury at work?  M 1  Yes 2 No	28d. Describe ho	ow injury occurred	
Divis	ital or At irs after o al Direct led in by		4 Homicide determined 28e. Place of Inj building, et	ury - At home, farm, stre c. <i>(Specify)</i>	eet, factory, office	28f. Location (St. City or Town		Rural Route Number,
	the Hosp nin 24 hou the Funei npletely fil	Medical	29a. Certifier 12 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Tactitioner: To the	examination and/or invest	igation, in my opinion, death occurred at the time, date and	d at the time, date an	nd place, and due to	the cause(s) and manner stated.
	P Im P In S		29b. Signature and title of certifier		29c. License number D062283	2	29d. Date signed (M 11/19/201	ionth, Day, Year) . 2
			30. Name and address of person who completed cause of c Keith Horvath MD 8600 Old	, , , , , , ,	· ·	MD 20814		
	Sta Registra			ar's Signature		20017		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MNov 28, 2012 Year 6:00 AM<sub>M</sub> Richard Allen Johnson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Allegany **Examiner** 4b. City, Town, or Location of Death 604 Winifred Road Cumberland 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Hours 168-34-3075 Mar 28: 1940 72 Director 1 **™**M 2 □ F Usual Residence of Decedent 28a-f show 10c. City, Town or Location Cumberland 10a. State 10b. Cour must be notified at 10d. Inside City Limits Director Allegany MD 1 Yes 2 No 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country' 23a Funeral 21502 604 Winifred Road USA within 72 hours after death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Examiner Armed Forces?
1 ▶ Yes 2 □ No If Yes, Give 0.0 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. white Specify. "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiers Important: If item 27 is marked other than any injury or other traumatic event, the Menone. Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Supervisor Sears Roebuck Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid Dorothy May Ullery Maiden Surname) ပ္ William H Johnson 19a. Informant's Name/Relationship (Type, Print) Richard Johnson 19b. Mailing Address (Street and Number of Red Poute Number City Vi Town State, Zip (Add) 21772 . Page 1 and 2 sh ment of Health a son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗀 Remgval from State Scarpeniffuherar Home, P.A. 11/28/2012 MD Cresaptown 4 Donation Other (Specify) 21. Signature 22. Name ar Scarpellif Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death heart failure. List only one cause on each line shock, of heart failu Immediate cause (Final Physician/ disease or condition resulting in death) Metastatic Adenocaro 7/200 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ Por in the past 12 months? Dav Year Pregnant at time of death 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\nearrow$  Residence 6  $\square$  Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No X Natural Accident Suicide the Investigation **Director:** 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State, To the Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 06-2011

Mds

State

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who completed cause of death (Item

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registrar's Signatur

gren MD

nth, Day, Year NOV 29

00023371

500 Willowbrook RD Site 440 Cunspaland MD 21500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40448 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25<sup>Day</sup> Physician/ NOV. ImbOE 2012 16:57 HILE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Howard 3713 Chatham Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) . Birthplace (State or Foreign Country) **Funeral** Hours 220-07-4297 Director 1 M 2 X F 93 08/06/1919 MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 3713 Chatham Road 21042 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White. etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes Give 3 ₺ Widowed 4 □ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Rita Shanahan Martin Knecht traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Ellicott City, MD 21042 3713 Chatham Road David Jarboe - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 11/30/2012 4 Donation 5 Other (Specify) Baltimore, MD New Cathedral Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ ARRHYTHINA disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit OVSESTER that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death the 2 1 ☐ Yes ∠ p Unknown P.O. I been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? 2 🗌 No 1 Yes filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 No Other: ၀ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Hospital or Attending (Month, Day, Year) 5 Pending 1 Natural 1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier া Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 10 29c. License number 2856 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I LENG MO 11055 Little Paraled 1 JERRY

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40449 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Johnson Donald Elmer 1530 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) Director 475-30-9814 1 X M 2 □ F 81 01/20/1931 Minnesota show 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "netural", or items 23a or 28a-f sho other traumetic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Howard Elkridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7335 Brookview Road #206 21075 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. or i Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: should be filled within 72 hours aft and Mental Hygiene.

is marked other than "netural", If Yes, Give 3 ☑ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Entrepreneur Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Elmer Reeves Johannes Johnson Edna Mildred Dennis use 1 and 2 shc uspartment of Health and Importent: If item 27 is ma any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall Johnson - son 7100 John Calvert Court Elkridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗶 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Johns Lutheran Cem 11/27/12 Columbia, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Preumonio disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy the Hospital or Attending Physicien: The I thin 24 hours after death. the Funeral Director: After this certificate h mpletely filled in by the funeral director, page performe 2 No 1 🗌 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕅 No ပ္ 1 Minpatient 2 ER/Outpatient 3 DDA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗆 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within To the 29b. Signature and title of certifier D0066515 Vov 23 2012 15+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rawat 5755 Cedar Lane 21044 Columbia, MD 31. Date filed (Month, State egistrar's Signature resend Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla	ınd / Depa	artment of F	lealth and I	/lental Hyg	iene	
			State Registrar	Cer	tificate of L	Death	R	eg. No. 2	2 1.01.50
ı	Physicia Medi		1. Decedent's Name (First, Middle, Last)  Burbara A Kull	щ			2. Date of Deat Month	Day Ye	3. Time of Death
	Exami		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of [	
11.5	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Vearl 9.	Birthplace (State or Foreign Country)
l.	Director		214-32-0433   Usual Residence of Decedent	Yrs.			01/20/1		Alabama
	ryland -f shoried at	ctor		City, Town or Loc					10d. Inside City Limits
	he Ma or 28a s notifi	Director	Maryland Baltimore I  10e. Street and Number	Baltimor	10f. Zip Code			0g. Citizen of Wha	1X Yes 2 No
	s 23a nust be	Funeral	433 Kenneth Square		21212		] '	USA	Country?
936	nit. Page 1 and 2 should be filled within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in the Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates,	lf lf	Vas Decedent of Hi f Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. <b>White</b>
2-0(	2 hours "natur idical l	plete	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupa			16b. Kind of Busine	
121	filed within 72 al Hygiene. I other than " vent, the Me	Completed	Elementary/Secondary (0-12)	life. DO	kind of work done d D NOT use retired)	uring most of work	ng	77 7.1	
nd 2	filed w al Hygi d other event, 1	Be	17. Father's Name (First, Middle, Last)	Nurse	2	18. Mother's Nam	e (First, Middle, M	Healthc aiden Surname)	are
Maryland 21215-0036	should be file h and Mental h 7 is marked o raumatic eve	2	Richard Monroe Hooks				Persons		
	nd 2 sho ealth and n 27 is r er traur	8	19a. Informant's Name/Relationship (Type, Print) Anna A. Kasko/Niece	19b. Mailin 433	g Address (Street a Kenneth	nd Number or Rura S <b>quare</b> , E	Route Number, G Baltimore	City or Town, State,  MD 212	Zip Code) 12
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		1 K Burial 2 Cremation 3 Removal from State		sition (Name of natory or other place morial Park	) [	Date 2 28/2012	20c. Location - City	
Balt	permit. Departr Import. any inji		21. Signature of Funeral Service-Licensee	l He	Name and Address Olloway F Ol Snow F	uneral H	ome Prof	essional	Association
ارسا	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the decishock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	ath. Do not enter	r the mode of dying	, such as cardiac c	r respiratory arres	t,	Approximate Interval Between Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consec	guence of):	Ke				years
	cuted nd fransit	Examiner	cause. Enter Underlving Cause (Disease or Injury that initiated events  c						
	ate be executed physician and the burial-transit	dical E	resulting in death) Last Due to (or as a consec	quence of);					
3760	ficate g phys	Medic	d						
. Box 687	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregrate 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
0.	that th ned by e detac	oy Ph	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds,	equires een sig nould b	ted					1 🗆 Yes	2 <b>1</b> No 3 1	Probably 4 \( \sum \) Unknown
Reco	Physician: The law re this certificate has bu ral director, page 2 sh	Completed					24a. Was an autopsy perform	ed? prior t	autopsy findings available to completion of cause of ? Yes 2 No
/Ital	sician certifi	00	25. Was case referred to dical examiner?  1  Yes 2 No Hospital: 1 I postiont 3	7	Othor	ce of Death (Check			4, / **
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Certificate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28b. Time of injury	3 L DOA 28c. Injury a work?	4   Nursing Hor	ne 5 Residen 8d. Describe how		ecity) assisted living
DIVISI	tal or Atter safter de al Directo ed in by the		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specification of the suit o	ome, farm, stree y)	et, factory, office	2	28f. Location (Stre City or Town,		Rural Route Number,
	he Hospii iin 24 hour he Funera	Medical	29a. Certifier (Check only one)  2 Certifying Physician: To the best of my know Check only one)  3 Certifying Nurse Practitioner: To the best of	on and/or investic	nation in my opinion	death occurred at	the time date and	place and due to th	a causala) and manner stated
	Voit Voit		29b. Signature and title of certifier		29c. License r	number		d. Date signed (Mo	
	1 100		30 Name and address of person who completed cause of death (Iter	n 23a) (Type, Pri	int)	059189		11231	
	UIC		Jeremy Oaron no 5500	- Hyles	is May v.	w Corle	Bal	the n	0 21224
	Stat Registra	<b>-</b>	31. Date filed (Mohrh, Del. Y2/8 2012 32 Registrar's Signal	B. Sa	Mar				

			For State Registrar	State of Mar		artment o					2012	40451
	Physicia		1. Decedent's Name (First, Middle, Last)  Margaret Gertrude	Knoebel			•		2. Date of Dea		.8,2012	3. Time of Death 10:50 PM
	Medie Examir		4a. Facility Name (if not institution, give str 202 Rolling Road	reet and number)	<u></u>		vn, or Location chersbu		NOVEIND	4c	. County of Deat	h
	Funeral Director		5. Social Security Number  206-14-7055  Usual Residence of Decedent	7. Age (i	87 Yrs.	If Under 1 Months E	rear If Under lays Hours	er 24 Hrs. Min.	8. Date of Bird (Month, Da July 2	y, Year)	Cot	hplace (State or Foreign untry) nsylvania
	aryland a-f show fied at	ector	10a. State 10b. County  Maryland Montgon	1	Oc. City, Town or Lo							10d. Inside City Limits
	th the Ma 3a or 28 be noti	Funeral Director	10e. Street and Number	.02)	0020110	10f. Zip Co			Ţ		tizen of What Co	untry?
	eath wi	uner	202 Rolling Road  11. Marital Status	2. Was Decedent Eve	er in U.S. 13.		0877 of Hispanic C	rigin? (Spe	cify Yes or No- Rican, etc.)		ed Stat	
9600	urs after d tural", or i	ted by I	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates.	、 I	If Yes, specify			Rican, etc.)		Black, White Specify: V	o, etc. Vhite
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with finity or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual C kind of work d IO NOT use rei haser	one during mo	ost of workir	ng		ind of Business/	ographic
yland	s should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, <u>the Me</u> s	To Be	17. Father's Name (First, Middle, Last)  John Erwin		·			ther's Name 1en P	(First, Middle, arker	Maiden	Surname)	
, Mar	id 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type Richard C. Knoebel								Town, State, Zip MD 20877	
Baltimore, Maryland	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 Ā Cremation 3 Ā A 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disponentery, cre. Metropol	natory or othe	em.	New i		Ale	ocation - City or xandr1a,	
Balt	permit. Departi Import any Inji		21. Signature of Funeral Service Licensee	A //					ol Fune r. Gait		Home sburg, M	D 20877
,,,,,,,	Physician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the cause on each line.  Senile D		er the mode of	dying, such a	is cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):							
	ted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):							
00	te be executed nysician and he burial-transit	ical Ex	that initiated events c. resulting in death) Last	Due to (or as a o	onsequence of):							
3876	eath certificate attending phy I for use as the	/Med	IF FEMALE:	a If you autooms of								
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	c. If yes, outcome of  1  Live Birth 2  4  Pregnant at ti  9  Unknown	Fetal death 3	☐ Ectopic pred ☐ Other (speci			·		23d. Date of del Month	ivery Day Year
ls, P.O.	requires that the des been signed by the should be detached	ed by P	Part II. Other significant conditions cont	ributing to death but	not resulting in the	underlying cau	se given in Pa	rt I.	1			the cause of death?
of Vital Records,	The law rec rate has bee page 2 sho	Completed by							24a. Was autop perfo 1  Yes	osv	prior to d	copsy findings available completion of cause of
E	nysician: T nis certifica I director, I	Be	25. Was case referred to medical examiner?	spital:		-	6. Place of De	eath (Check		2 - 140	0	
fΧ	Physic this c ral dire	잍	1 ☐ Yes 2 ☒ No		2 ER/Outpatie						Other (Speci	(fy)
ion o	tending I leath. tor: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, \		м	Injury at work? 1 ☐ Yes 2 [	- 1	8d. Describe h	ow injur	y occurred	
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: A -completely filled in by the I		4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, sti Specify)	eet, factory, of	fice	2	28f. Location (S City or Tow			al Route Number,
	he Hosp iin 24 hou he Funei ipletely fi	Medical	29a. Certifier (Check only one) 1 X Certifying Physic 2 Medical Examine 3 Certifying Nurse	r: On the basis of example of example of the control of the contro	mination and/or inves	tigation, in my	opinion, death	occurred at	the time, date a	nd place	, and due to the o	ause(s) and manner stated.
			29b. Signature and title of certifier				37142				te signed <i>(Month</i>	
			30. Name and addless of person who con Dr. G. Coleman M.		th (Item 23a) (Type, I Muncaste		Road,	Rockv	ille, N	1D 2	0855	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 0 2012	32 Registrar's	Signature	del.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shakiru Kazeem Month - 23 - 2012 4:46 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Southern Maryland Hospital PG Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 214-25-0753 53 Director 1 **X** M 2 □ F 2-7-1959 Nigeria ir than "natural", or items 23a or 28a-f show the Medicel Examiner, just be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Md. PG District Heights 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? era 2620 Timbercrest 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Yes 2 X No Yes, Give Black White etc 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** 3 ☐ Widowed 4 ᡮ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pege 1 and 2 should be filed within 72 Department of Health end Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4 or 5+) Driver Taxi Cab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rasaq Kazeem Wosilat Kazeem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Cedar St, N.W.#1, Washington, D.C. 20011 Ronke Kassim / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemet. 4 Donation 5 Other (Specify) 11-24-12 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 411kennedy St, n.W. Universal Mortuary Inc, Washington,D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) e burial-transit or Attending Physician: The lew requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The lew requires that the death certificete be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Completed by Physician/Medical € M € P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) မြ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕒 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

26 2012

(Check

29b. Signature and title of certifier

81. Date filed (Month, Day, Year) NOV 28 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammad Naceum 625 Keul

32. Registrar's Signature

Completed by Funeral Director

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Physician/Medical Examine

To Be Completed by

Certificate:

Medical (

Physician/

Medical

**Examiner** 

**Funeral** Director

Registrar	<i>(</i> =	7 - *			Cei	rtificat	e of L	Death				. No.2	110	2	4045
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertillying Number Prantification To the best of my contest, and the first date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

D 21502

29c. License number

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gregory Alan Kight Medical T.2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number 8. Date of Birth (Month, Day, Year) 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** 217-82-2267 Director 1 💢 M 2 🗆 F 53 May 17,1959 Marvland Usual Residence of Decede Show 10a State with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Washington 1 X Yes 2 □ No Md. Hagers town 10e. Street and Numbe 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 2 W. Franklin St. Apt. 21740 U.S.A death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after dear th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner. Black, White, etc. by 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 Tes 2 X No Specify White Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenace Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (*First, Middle, Maiden Surname*) Camilla Julia D'Atri ပ Charles Lester Kight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a If item 27 is or other tra Michael J. D'Atri (Uncle) 756 Bishop Walsh Rd. Cumberland, Md. 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or Smithsburg Crematory Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facility Lea 12525 Bradbury Smithsburg, Md. Aye 21783 M01414 J.L. Davis Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Ph.si.i.n erebrat disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DISTASE Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Exami tas that the death certificate be executed DIRBK that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph d for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery bed by the atter 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No g Unknown Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed certificate 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 1 Yes 2 No မ 1 Impatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending s after death. 1 Yes 2 No the 1 2 Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State, within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely | Certifying Prijstician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 0060 396 12/05/12 Myl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) opal Hagerstown 1126 ARID SHED 31. Date filed (Month, Day, Year State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar			of Marylar	nd / Depa		nt of H	lealth		lental Hy		2013	
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faryland 8 <b>a-f show</b> tified at	ector	10a. State	10b. County	egany		ty, Town or Lo umber1a						_	· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits 1 X Yes 2 □ No
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marr 3 ☒ Widowed		Armed Fo	2 □ No ⁄e रमार			cify Cubar	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify: Wh	ite, etc.
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.  To the Funeral Director, Affect this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 🗌 Live	come of pregna Birth 2  Fet nant at time of nown	al death 3	Ectopic p Other (sp		у				23d. Date of de Month	elivery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40456 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death November 23 Physician/ LEMON 11:34AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death

PLINCE 6-City RS **Examiner** CTURS Community Hospital LANHAM If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Director 1 M 2 X F 62 SOLHACABINA 1950 28a-f show with the Maryland 10a State 10c. City, Town or Location Examiner must be notified at Director 1 Yes No OWIR 0 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 2005 2072 CONNOR UNITED STATES permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Tes 2 No Baltimore, Maryland 21215-003 Specify: BIACK 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Important: If item 27 is marked other than Elementary/Secondary (0-12) ENTRY MANGGET Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ertice SINIG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wallacesister Bowle MD 700 ox Bridge Way 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MGINNING; SC ANTFOCH Memorial Leadens 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee ma1388 106845044ErN MO BIVD DUNKIRK, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sevi Sequentially list conditions, if any leading to him class cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe within 24 hours after death.

To the Funeral Director, After this certificate ☐ Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: Certificate: To 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d. Date signed (Month, Day, Year) 26 MDD6061 inpleted cause of death (Item 23a) (Type, Print) and No. 8118600dhuckld. 19.95 MD. 20706 ankam Samu State Registrar

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		1	For State Registrar	ate of Marylan	-	eartment of F artificate of E			liene leg. No 2 0	2 40457			
	sicia		Decedent's Name (First, Middle, Last)     Harry Edward Le1	and, Jr.				2. Date of Dear Month	Day Yea	3. Time of Death			
	ledic amin		4a. Facility Name (if not institution, give street			4b. City, Town, or	Location of Death	1101 Cmp	4c. County of D	, sc			
espano de la compansión			Manor Care-Potomac  5. Social Security Number   6. Sex	7. Age (In yrs. la	et hirthday)	Potom	ac If Under 24 Hrs.	8. Date of Birth	Montgom				
Fun Direc	_		530-26-2193 ¹™™		Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 1.	Year) 1923	Birthplace (State or Foreign Country) VA			
and	iat	or	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits			
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Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o	Medical	Completed	15. Decedent's Educatio (Specify only highest grade con		(Give life. E	edent's Usual Occupa kind of work done do DO NOT use retired)		ing	16b. Kind of Busine	ess Industry			
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Baltimore, Maryland permit. Page 1 and 2 should be filee Department of Health and Mental H Important: If item 27 is marked out	y or othe		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	20c. Location - City									
Baltir Departmi Importar	any injur once.	İ	21. Signature of Funeral Service Licensee	0	F.	tan Cremat	s of Facility. Collins	Funeral	Home Inc				
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Division of Vital Records, tal or Attending Physician: The law requires rs after death. al Director After this certificate has been sign in the table formed director actions a considerable.	ed III ba		4 Homicide determined	e. Place of Injury - At hor building, etc. (Specify)		reet, factory, office		28f. Location (St. City or Town		Rural Route Number,			
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			30. Name and address of person who complete Pinky Singh, MD 1	ed cause of death (Item 0714 Potoma	23a) (Type, I	Print) nis Lane.	Potomac	MD 208	54				
	Stat jistra	-		2. Registrar's Signatu									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19. Physician/ Month Philip Dewey Lee 10:01 a<sup>M</sup> November 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 510 Gilmoure Drive Silver Spring
If Under 1 Year If Under 24 Hrs. Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 193-12-1116 Country) **Director** 1 🗗 M 2 🗆 F 88 March 23, 1924 Usual Residence of Decedent PA r than "natural", or items 23a or 28a-f sho 10a. State 10b. County filed within 72 hours after death with the Maryland 10c, City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 X No Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? Funera 510 Gilmoure Drive 20901 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: SpecifyWhite 3 Divorced Completed Year or Dates. 1943-45 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene, I other than " Elementary/Secondary (0-12) College (1-4 or 5+) S<u>ervice Manager</u> Management permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dewey Lee ၉ Grace Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia L. Martin/Daughter 340 Springhouse Lane, Moorestown, NJ 08054 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 19, Nov. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Euter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or conditi-resulting in death) Metastatic Prostate Cancer vrs Medical Due to (or as a consequence of): Examiner Prostate Cancer Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the chianger that the contraction of the chianger that the contraction of the co that initiated events Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 \_ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day signed by the ar 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24 hours after death. • Funeral Director: After this certificate has been signed in by the funeral director, page 2 should t 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ٥ 1 Tes 2 🔯 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide 1 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueatin occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

complete only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35996 10+1 Nov. 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burrell, MD 2730 University Blvd. #400, Wheaton, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 0 201 Registrar

LAMB GDDIE

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	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Eddie N. Lamb	Cer	tinicate or L	Death	2. Date of Dea Month		Year	3. Time of Death
2	Medic Examin		4a. Facility Name (if not institution, give street and number)  Doctor's Hospital		4b. City, Town, or Lanha	Location of Death	Novem	4c. County	of Death	Georges
	Funeral Director			s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 02/19	, Year) / 1951	9. Birthp Count D •	
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	h with the ns 23a or 3 nust be no	neral Di	10e. Street and Number 6218 61st Place		10f. Zip Code 207	737		10g. Citizen of V	What Coun	•
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 🖾 Never Married 2 🗆 Married  3 🗆 Widowed 4 🗆 Divorced  12. Was Decedent Ever in Armed Forces?  1 🛣 Yes 2 🗀 No 1 ff Yes, Give Year or Dates.	U.S. 13. \	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No		ecify Yes or No- Rican, etc.)		e - Americ ck, White, e Bl	
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Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		1 M Burial 2 Cromation 2 Demous from State	b. Place of Dispo cemetery, cren Quantic	osition (Name of matory or other plac O Natio	e)	Date 23/12	20c. Location -		
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licenses CC0530	) 22	2. Name and Addres	ss of Facility La	tney's	Funer	al H	
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. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burian the signed.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Da Mo	te of delive	ery Day Year
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State of Maryland / Department of Health and Mental Hygiene

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29b. Signature and title of certifier  29c. License number  O.C.M.E.  November 19, 2012  30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, Pax Year)  29c. License number  O.C.M.E.  November 19, 2012	Diva aff		4 Homicide		not be			.,	,		orig, oto.				and Number	OI Kuit	al Route Number, City
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Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  O.C.M.E. November 19, 2012  November 19, 2012  30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	To vitt	Med			and manner s	tated			_				timo, date		_		
30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Monta Pax Year) 2010 32. Registrar's Signature		-1	Parotito	with	11 mh												
Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31 Date filed (Month (Month (Month)) 2010 32 Registrar's Signature		ŀ	30. Name and address	of person w	ho completed cau	se of death (Item	23a)									J, 20	
State 31. Date filed (Month, Day Year) 32. Registrar's Signature	11+11		Pamela E. Sou	uthall, ME		,		900 V	V. B <b>al</b> tir	nore S	Street, E	Baltim	ore, MD 2	1223			
		ate	31. Date filed (Month	Jax ( eat)	2012 32. Ry	gistrar's Signatu	ire /	6.	.0 8								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Director 579-22-3732 1 X M 2 □ F 09-24-1925 Wash., D.C. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 1 No North Beach Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 858 Bayfront Avenue 20714 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 

Yes 2 

No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No 3 Widowed 4 Divorced Completed Year or Dates. 1943-45 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Union Construction Steamfitter æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Truman Lohr, Sr. Nora booW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma C. Lohr, Spouse P.O. Box 219, North Beach, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 11/27/2012 Cheltenham, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. M00715 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Kectal disease or condition resulting in death) Ance hoow Medical Due to (or as a consequence of) Examiner evmones Sequentially list conditions, if any, leading to immediate cause. Futer 11 donying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ၉ 1 Pinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

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State Registrar Trac

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra's Sig

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11-16-2012

12-08953 Larry Olen Lowery Amended #s 11, 12, 13; nls, per FD, 11/28/12, Allegany Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 40462 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 24, 2012 **Medical Examiner** Olen Lowerv 1945 hrs Larry 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1500 Pennsylvania Avenue Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign MD Months Davs Hours Min Jun 18, 1957 Director 213-64-7594 1 M<sup>X</sup> 2 F Usual Residence of Decedent <sup>10c. City, Town of Location</sup>
Hagerstown 10b. County Washington 10d. Inside City Limits 1 Yes 2 No narked other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at once. isaltimore, MD 21215-0036

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
In Important: If item 27 is marked. 10e. Street and Number 10f. Zip Code 10g. Citizen of What 21740 1500 Pennsylvania Avenue Funeral 11. Marital Status
1 X Never Married 2 Married Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Coppan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. white \_ Yes 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Specify. 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) none disabled 17. Father's Name (First, Middle Last) Last) Thomas Theodore Lease 18. Mother A Pape (First | Widdle, Maiden Surname) 8 19a. Informant's Name/Relationship (Type, Print ) 19b. Malin 2424 Mr Savage Road Mit Savager, State, ZiMP 21545 item 27 is m brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 11/28/2012 Burial 2 Cremation 3 Removal from State Lease Cerheters Cresaptown MD 4 Other Specify 22. Name and SCO PER CHARLES THE, n ture of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 Tayl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician List only one cause on each line. Between Onset and /Medical Death a. Spinal Injury with Complications Immedia Cause (Final disease or consion resulting in death) xamine Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED ficate has been signed by the attending physician page 2 should be detached for use as the bunal Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has funeral director, page 2 s performed? death? 2 No Yes 2 V No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 2 Other: Scene ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Feb 2, 2012 Ejected driver auto collision 1 Natural 0900 hrs 1 Yes 2 ✔ No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Ellerslie Road at Teddy Bear Trail, Ellerslie, MD determined Homicide (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiners the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and the of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 26, 2012 mpleted cause of death (Item 23a) MRS Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Registrar's Signatu State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 3. Time of Death Physician/ Month Ann Bell Myers novem Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. Comico Rehab/NULSING 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min. Country) Director 1 □ M 2 🕱 F 215-70-5005 Yrs. 87 April 1, 1925 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 KX No Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9246 Claire Circle 21875 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. \$ 1 X Never Married 2 Married ☐ Yes 2 🛣 No 1 Yes 2 X No Specify: Yes. Give 3 Widowed 4 Divorced white Baltimore, Maryland 21215-00 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Pierce Albert Myers Eva Orndorf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21875 Darlene Goodman (Daughter) 9246 Claire Circle Delmar, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 11-28-2012 Delmar, Delaware 21. Signature of Funeral Service Lious 22. Name and Address of Facility 13 East Grove Street Short Funeral Home Delmar, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Lis tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician/ Scene Medical resulting in death) Examiner Sequentially list conditions, if any leading to inspectate cause. Enter Underlying Due to für as a consequence off Examine or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, Completed 1 Yes 2 No 3 Probably 4 Unknown been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has the director, page 2 s autopsy performed 1 Yes 2 No of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 0 10 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun Division Investigation Suicide
Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 8 6 pleted cause of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar 40464 Reg. No.Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month  $p_{M}$ Middleton 2012 Joseph Thomas Sr. November 2:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 200 Hall Drive Salisbury Wicomico Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 218-24-6154 83 1 🛛 M 2 🗌 F 09/22/1929 Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Wicomico Salisbury 1 🗌 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 200 Hall Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ▼ Yes 2 No If Yes, Give Year or Dates Navy filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White 27 is marked other then "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dispatcher Electric Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental .. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o မ Benjamin Houston Middleton Maude Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Middleton/Spouse 200 Hall Dr., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State Parsons Cemetery 11/28/2012 Salisbury, MD Donation 5 D Other (Specify) 21. Signature of Funeral Service Licens 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dompron 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a consequence of): YEAR Medical Examiner Athenoscieros XEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death
9 Unknown signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC KIONEY DISEASE 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? DEMENTIA 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 1 Residence 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Procuring Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D36576 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 RONALD P\_ MO KG5 WOODBROOK DIE TRAVITZ SALISBURY Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month M.DCA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 23 N. Huron Drive Oxon Hill Prince George's 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 578-50-8389 Director 1 🗆 M 2 🔽 76 March 9, 1936 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Importent: If time 27 is amended other than "natural", or items 23a or 28a-f show limportent: If time 27 is amended other than "natural", or items 20a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Upper Marlboro Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10202 Prince Place # 202 20774 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☒ No If Yes. Give Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 ☒ No Specify: Specify: American 3 🗌 Widowed 4 🔲 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Day Care Provider Private 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillie Lee Jackson James Elsworth Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20745 23 N. Huron Drive Oxon Hill, Maryland Wendy A. McDowell - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Waldorf, Maryland Heritage Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 4001 Benning Road NE 20019 Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, from Leading Comments of Cause. Enter Underlying Cause (Disease or injury Visit introduce or injury Visit introduce or injury Visit in the Cause of Cause (Disease or injury Visit in the Cause of Cau Due to for as a nonsequence of sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 month 1 Yes 2 No Month Day been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has talirector, page 2 s autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical of Vital funeral director, Be 26. Place of Death (Check only one) Daughter's Residence ence 6 Dother (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕢 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ours after death.

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filled in by the fur Division Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marner as stated only one) 3 350 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) pelense nway Annapolis 110 21401

DHMH 17 Rev 06-2011

Registrar

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Baltimore, Maryland 21215-0036

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year NOVEMBER 26,2012 11:04 PM MARJORIE MACKEY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9016 CANTERBURY RIDING PRINCE GEORGE'S LAUREI 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days (Month, Day, Year) Director 212-68-2111 1 ☐ M 2 🂢 F 56 WASH. D.C. MARCH 25,1956 e filad within 72 hours efter deeth with tha Maryland itel Hygiene.

ed other then "natural", or items 23e or 28a-f show avent, the Medical Evarilher must be rediffied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD PRINCE GEORGE'S LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9016 CANTERBURY RIDING 20723 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CONCIERGE PROPERTY MANAGEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) a 1 and 2 should be fila of Health end Mantel H if Itam 27 Is marked of r other treumetic aver မှ WILLIAM BLADEN SHIRLEY FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARJORIE MOORMAN/DAUGHTER 9016 CANTERBURY RIDING, LAUREL, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Paga 1
Department of Importent: If it eny injury or o ö 1 X Burial 2 Cremation 3 Removal from State 11/30/12 Ft.Lincoln Cemetery Brentwood, Md. 4 Donation 5 Other (Specify) 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 20737 21. Signature of Funeral Service Lipensee M00091 5801 CLEVELAND AVE, RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death LUNG CANCER Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hoepitel or Attanding Physician: The lew requires that the death certificete be axecuted within 24 hours efter deeth.

To the Funerel Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Dav Year 9 Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) November 27/2012 as MD D72139 1024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 MD 21044 Q. ABBAS CEDAR LANE COWMBIA 31. Date filed (Month) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

of Vital

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ĩ5, George November 2012 9:20 A Edward Mantor Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 219 Creek Valley Lane Rockville Montgomery Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Director 074-05-3254 1 X M 2 🗆 F 96 June 12, 1916 New York Usual Residence of Deced 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified 1 X Yes 2 No Maryland Rockville Montgomery 9 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be ural", or items 23a Examiner must be Funeral 219 Creek Valley Lane 20850 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No 19 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1942 ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", Specify: 3 Widowed 4 Divorced Completed 1973 White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Command Sergeant Major 5+ U. S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည other traumatic George Mantor Emilv Havman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or with 219 Creek Valley Lane, Rockville, Maryland 20850 Mary A. Laser-Mantor - spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date UKN 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 🛣 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Arlington Nat. Cem. Arlington, Virginia 22. Name and Address of Facility Signature of Funeral Service Licens DeVol Funeral Home O East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on e.g. h line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to Examiner Sequentially list conditions if any lacong to immediate cause. Enter Underlying Examine e buria Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): nding physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the i P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 1 ☐ Yes 2 No ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Hospital Other: 4 Nursing Home မ 1 Inpatient 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotential DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 🗌 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) - MD 6095 Manshalae Dr. Elkvids Harrism Date filed (Month, Day, Year) State 32. Registrar's Signat NOV 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - State
Registra AMEND#29 doer MD11/29/12; BWW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margarita November Messersmith Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death -durel Regional Hospital Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 578-42-4137 Months 81 Director 1 □ M 2 🏝 F Nov. 25, 1930 China Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director must be notified or 28a-f MD P.G. 1 Yes 2 X No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 3158 Gracefield Road, #322 20904 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes. Give 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Dwight L. Sherertz Margarita M. Park 1 and 2 should by Health and Meinten 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Howard Messersmith/Husband Department of Health Important: If item 27 any injury or other tr 3158 Gracefield Road, #322, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🖾 Removal from State Dec 12 Ottawa Hills Memorial 4 Donation 5 Other (Specify) Toledo, OH 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. p00 University Blvd. W., Silver Spring, Part 1. Inter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary disease or condition Medical resulting in death) **Examiner** Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and I for use as the burial-transit Hypertension Cause (Disease or injury that initiated events D Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? performed Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **1** No 1 Yes ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I 4 Nursing Hame 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation apletely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1772380 ompleted cause of death (Item 23a) (Type, Print) Noah Gutierrez, MD

State Registrar DHMH 17 Rev 06-2011 Laurel Rejional Hospital

31. Date filed (Month, Day, Year)

NOV 26

Box 68760

P.O.

7300 Van Dusen Road Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 11:30tM Me1ton Pamela Erin November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Collingswood Nursing & Rehabilitation Montgomery Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🖾 F Months Days Hours Min. SEP 23, Year 56 019-50-1919 56 Yrs Director Georgia Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a Rockville 1 X Yes 2 No Maryland Montgomery 10f. Zip Code 10e. Street and Number 10a, Citizen of What Country? Funeral 20850 299 Hurley Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 X Divorced American Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Hygiene. permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I Civil Service Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Clinton Columbus Melton Goss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code  $\mathtt{Unit}\#2\overline{19}$ 19a. Informant's Name/Relationship (Type, Print) 5385 Peachtree Dunwoody Rd., NE, Atlanta GA 30342 Jennifer Melton / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Atlantic Crematory Glen Burnie, MD 11/26/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral <sup>22</sup>. Name and Address of Facility Thibadeau Mortuary Service, P.A. M00956 Park Avenue, Gaithersburg, 23a. Part . Entarthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Metastatic Breast Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, Examiner Due to for as a consequence of and To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Chronic Pain that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Por in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death detached the g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 2 🗌 No Yes 2 X No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other: 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 A Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred work? 1 ☐ Yes 1 X Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Neglical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Petrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Ahmed Heshmat,

NOV 26 2012

31. Date filed (Month, Day, Year)

29c. License number

D0057574

2401 Research Blvd., Rockville, MD 20850

29d. Date signed (Month, Day, Year) November 22, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Physician/ Miller Olivia Martin Medical 11/17/2012 2:50 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda, MD Montgomery Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Hours Min. **Director** None 1 M 2 F 06/09/1982 Washington, DC ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 10807 Pleasant Hill Dr. 20854 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 ☐ Married Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ith and Mental Hygiene.
27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) None None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) G. Hall Martin Kathleen Miller and 2 should be Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr G. Hall Martin/ Father 10807 Pleasant Hill Dr., Potomac, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 11/20/2012 | Falls Church, VA Signature of Funeral Service Licensee 22. Name and Address of Facility 5130 Wisconsin Ave., NW M01276 Joseph Gawler's Sons Washington, DC 20016 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death Respiratory Failure/ Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner 1 Day Hepatic Encephalopathy Sequentially list conditions, If any, leading to immedicause. Enter Underlying Cause (Disease or injury Due to for as a consequence on Physician/Medical Exam that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) Month Year Pregnant at time of death a | I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hospital or Attending Physician: The law requires Records, 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 X N death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? of Vital 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No ျ 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
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3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 1)60/68 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEJAW MEKONNEN 20854 1201 Seven Locks Road; Rockville, MD

DHMH 17 Rev 06-2011

Registrar

Date filed (Month, Day, Year)

NOV 2 6 2012

Martin

72. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 40472 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vear Katherine Delores Malengo ам 10:45 Medical November 2012 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Collingswood Nursing & Rehab. Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours Min 198-20-0313 Director 1 🗆 M 2 🕱 F Yrs 86 Usual Residence of Deceden April 8, 1926 PA of Heelth and Mental Hygiene. item 27 is marked other then "natural", or items 23e or 28e-f show other treumetic event, the Medical Evantiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3209 Medway Street 20902 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No SpecifyWhite 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Permit. Page 1 and 2 should be filed wit.
Department of Heelth and Mental Hygier Importent: If item 27 is marked other theny hijury or other them. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fedele Marella Rachel Cavoto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Malengo/Husband Medway Street, Wheaton, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 26, Nov. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W.,Silver 23a. Part 1. Enter the disease, or complications that fayled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cau Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ue to (or as a consequence of attending physicien end I for use es the burlal-transit Hospital or Attending Physician: The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4 Pregnant 5 Other (specify) Month Pregnant at time of death Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Funerel Director: After this certificate has been si completely filled in by the funeral director, page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funerel Director: A 2 Accident Investigation 1 🗆 Yes 2 🗌 No Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. 0 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 For State Registrar 40473 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death November 23, 2012 **Physician** 9:55 A. M Malcolm Alfred Marquess /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnett - Calvert Hospice House Prince Frederick Calvert 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Months Days Hours Director 216-22-1296 86 06/08/1926 Maryland Usual Residence of Decedent er nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show ny injury or other traumatic event, Ite Medical Eventine in talt be nettlined at notes. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 Owings Hill Court 20736 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1V Yes 2 D No 174es, Give Year or Dates: 1945–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ. Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) plant foreman asphalt company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Lawrence Marquess Nora Cochrane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele A. Nelbach, daughter 230 Owings Hill Court, Owings, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 11/29/0212 | Cheltenham MD 22. Name and Address of Facility of Funeral Service Licensee Rausch Funeral Home. P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMYCRATION /Medical Due to ( as a consequence of): Examiner dementa WUNCED Secupertally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) signed by the a d be detached for Division of Vital Records, P.O. 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should b Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate har funeral director, page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{PlOther} \) (Specify) HQS \( \text{PlUL} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred House 1 Natural
2 Accident 5 Pending investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b Signature and title of cart fier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address who completed cause of death (Item 23a) (Type, Print) Merrimac Ct Prince Fred 6+ 238 32. Registra s Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19<sup>Bay</sup> 20<sup>Year</sup>2 Mary Hazel Martin 1:54a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Snow Hill Nursing & Rehab. Worcester Snow Hill 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 89 6 10 Day 1923 266-30-6642 TN. Director Usual Residence of Decedent show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 430 W. Market Street 21863 USA "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 ☐ Widowed 4 🛭 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ Charles Albert Hodges Susie Jane Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Gordy-Daughter 415 14th st unit 55,0cean City, MD. 21842 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) Intomb. Jefferson Mem. 11-25-12 Jefferson City, TN Service License 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD. 21811 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause ch line Immediate Cause (Final disease or condition resulting in death) DEMENTIA Onset and Death Physician/ ALZHEIMER'S Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Day Pregnant at time of death 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᇋ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 62172 11/19/2012.

State Registrar

Box 68760

P.O.

Division of Vital Records,

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHALAI) R SATYAC, WI) 1604 MANKET ST

POCOMORE CITY MD 21851.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4c Per PHY G935 1/10/2013 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:00 A M PATRICIA В. MARSHALL November 19 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5830 Cherrywood Circle 21838 Somerset Marion Station 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Fc un Country) Office Lise L Director 1 □ M 2 🕅 F 12/11/1956 <u>220-68-8188</u> 55 Maryland Usual Residence of Decede ?T is marked other than "natural", or items 23a or 28a-f show traumatic event, t<u>he Medical Examiner must be notified at</u> 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Somerset 1 Yes 2 No Marion Station 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5830 Cherrywood Circle 21838 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black White etc. δ 1 Never Married 2 M Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Branch Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert H. Bradshaw Betty June Owens I and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George E. Marshall (Husband) 5830 Cherrywood Circle-Marion Station, MD 21838 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H 1 Donation 5 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Sunnyridge Mem. Park 11/24/2012 Crisfield, MD 21. Signature Funcy Say Live 22. Name and Address of Facility Robert H. Bradshaw. Bradshaw & Sons Funeral 306 W. Main St. - Crist ar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cholangio carcinoma metastatic Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical # #C Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 W No 3 Probably 4 Unknown 24a. Was an autopsy performed? Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number D30690 2012 Nov. Do 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carroll ST. Solisbury MD Dones E. MARTIN M.O 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	epartment of Health and Certificate of Death		2012 1.01.16		
	_		Registrar  1. Decedent's Name (First, Middle, Last)	Dertineate of Death	Reg.	rieg, rioz-		
н	Physicia Medi		Emily S. Moran		Month November	mber 18 2012 7:04P M		
19-4	Examir		4a. Facility Name (if not institution, give street and number) 15111 Glade Drive, Apt.3A	4b. City, Town, or Location of Deat Silver Sprin	4b. City, Town, or Location of Death 4c. County of			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign		
	Director			rs.   Months Days Hours Min.	(Month, Day, Yea April 28	**		
	nd <b>how</b> at	۱	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location	110121 20	10d. Inside City Limits		
	is filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	MD Montgomery Sil	ver Spring		1 🗆 Yes 2 🔀 No		
	a or 2		10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?		
	th with ms 23 must	Iner	15111 Glade Drive, Apt. 3A	20906		nited States		
<b>'</b> O	or iter	by Fu	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.		
036	rs afte rral", e Exan	ed b	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🏲 No Specify:		Specify: White		
5-0	2 hou "natu edical	Completed	15. Decedent's Education 16a. [(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work	rking 16b	. Kind of Business/Industry		
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d 2	filed wi al Hygie d other event, tl	Be (	17. Father's Name (First, Middle, Last)	Homemaker  18 Mother's Na	me (First, Middle, Maide	Own Home		
/lan	d be fi Aental Irked Itic ev	은	Hans Schmidt	Margar		_		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked any injury or other traumatic eve once.		19a. Informant's Name/Relationship (Type, Print)  John Moran / Son  7	Mailing Address (Street and Number or Ru 312 Rosewood Manor	ral Route Number, City Lane, Layt	or Town, State, Zip Code) Onsville, MD 20882		
ore,	of Hex of Hex fitem rothe			Disposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State		
timo	. Page ment tant: I				′23/12 S	ilver Spring, MD		
3alt	permit Depart Import any inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ro				
	TD = 600		Francis Anthony Backer	P. O. Box 5038, La				
_I	hysician/ Medical		resulting in death)	emic Stroke with Ri		Approximate Interval Between Onset and Death 2 Weeks		
	Examiner		Due to (or as a consequence of)					
	ansit	dical Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
	ate be executed oblysician and the burial-transit	E	resulting in death) Last  Due to (or as a consequence of).					
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687	ertific ding p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					
P.O. Box 687	eath c atten d for u	Physician/Me	in the past 12 months?  1  Live Birth 2 Fetal death 4 Pregnant at time of death	3		23d. Date of delivery  Month Day Year		
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σ <u>.</u>	es tha signed I be de	by	Part II. Other significant conditions contributing to death but not resulting in t  Hypertension	he underlying cause given in Part I.		use contribute to the cause of death?		
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ecc	The law cate has I page 2 s	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?		
ا <u>س</u>	an: Th tificat tor, pa	Be Co	25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2 X			
<u>₹</u>	lysicia is cer direc	To B	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 ER/Outp	Othor	ome 5 Residence	6 ☐ Other (Specify)		
o j	ng Pr fter th uneral		27. Manner of Death  1   Natural 5 □ Pending   28a. Date of injury (Month, Day, Year)   28b. Time (Month, Day, Year)   28b.	ne of 28c. Injury at	28d. Describe how inju			
ion	ttendi death. tor: A the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No				
Division of Vital Records,	tal or Al s after or al Direct ed in by	Cert	4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)		
:	To the hospital or Attending Physicians: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, der	rvestigation, in my opinion, death occurred a	at the time, date and place	ce, and due to the cause(s) and manner stated		
1	Vithi To th	-	29b. Signature and title of certifier	29c. License number		Pate signed (Month, Day, Year)		
			Chalde 3amo Falusan	D 43202	No	ovember 19, 2012		
	~		30. Name and address of person who completed cause of death (Item 23a) (Typ.					
	Ctot		Charlene Ozanne-Johnson, M.D. 33 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature		d Blvd.,Si	lver Spring,MD 20906		
	Stat Registra	r	31. Date filed (Month, Dex, Year) 20 2012 32. Fegistrar's Signature	barles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month \ Physician/ 35 AM Joseph Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Maryland Medical Center Baltimore Baltimore niversity 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 421-36-9138 Director 1**X** M 2 □ F Oct. 23, 1925 Alabama Usual Residence of Dece 28a-f shov 10a. State 10b County 10c. City, Town or Location at 10d. Inside City Limits Director be notified 1 XYes 2 No Maryland Frederick Frederick 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21 Fairview Avenue "natural", or items 23 21 701 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 1. Marital Status 14. Race - American Indian, Armed Forces?
1 XYes 2 □ No Black, White, etc þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give White 3 - Widowed 4 - Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) Veterinarian Veterinary Medicine other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o မ John Buster Mayo Susan Simonton 1 and 2 should b f Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Frances Mayo/ Wife Fairview Avenue, Frederick. or other Maryland 21701 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cemetery 11/21/2012 Frederick, Maryland 22. Name and Address of Facility Keeney & Basford Funeral Home Signature of Funeral Service Licenses MO1646 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Invacranial hemorrham Medical resulting in death) Due to (or as a consequence of) Examiner Complications Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (ur as a consequence u) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and -trans Due to (or as a consequence of) burial-1 attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural
2 Accident 5 Pending ours after death.

neral Director: Af

filled in by the fu fail 11/10/12 2 down string Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 2 6 File Sew A determined Pairview Ave derick To the Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funer

completely fi 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 102299

Registrar

State

Baltimore

gistrar's Signature

21201

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(sceane

24

5.

31. Date filed (Month, De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Maltagliati December T, 2012 Marie 10:25A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Genesis Healthcare Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 578-24-3863 Days Hours June 24, 1926 Washington,DC Director 1 🗆 M 2 💢 F 86 Usual Residence of Dece ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Adelphi 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 20783 3210 Powder Mill Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married Black, White, etc. ģ Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Secretary Dept. of Interior permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any Injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelo Maltagliati Ambelia Ferrari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory A. Maltagliati -nephew 76 Cedar Dunes Drive New Smyrna Beach, FL 32169 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 12/5/2012 Silver Spring, Maryland 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pomald AW ress Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician, Instant Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Concestive Heart Failure 6 months Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events One to (or as a currequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Coronary Artery Disease 12 months ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death Day Year g Unknown To the Hospital or Attending Proysician, the land constituted that within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completely filled in by the funeral director, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Chronic Kidney Disease; Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🕅 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2ٍ| 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Magner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only oper 29b. Spnature and title of certifier 29d. Date signed (Month, Day, Year)
December 3, 2012 BAY D28656

151

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Segistrar's Signature

Ravi Passi, M.D. 15245 Shady Grove Rd., #130 Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40479 Registrar Amend #10E Per FH JM 11 Contificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 12:25AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNAPOLIS ANNE ARUNDEL HOSPITAL ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) Director 577-36-9003 1 X M 2 □ F 83 Yrs. 08-08-1929 WASH., DC 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 log Yes 2 □ No PRINCE GEORGE'S BOWIE MD 10e. Street and Number ENFIELD 10f. Zip Code 10g. Citizen of What Country? Funeral 3800 ENFIEDD CHASE COURT U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 V Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Mamied 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) PENTAGON PLANT SUPERVISOR traumatic event, Be Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked ott any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည PURCELL NORMAN, SR. ALBERTA ROLLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GWENDOLYN HARRIS-DAUGHTER 7913 BEACHNUT ROAD CAPITOL HEIGHTS, MD 20743 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) CREMATORY 12-8-2012 CLINTON, MD Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. CO203 0 E. WASH.. DC 20002-5236 - 8TH ST. N 23a. Part 1. Enter the disease, or complications that caused the disease, or heart failure. List only one cause on each line. Denot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ydration Physician/ disease or condition resulting in death) Medical week Examiner scular volume Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exam attending physician and if for use as the burlai-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the at the detached for Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2 No the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number M.D 2012 BUSAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tan win Medical 1culasing12 2001, 31. Date filed (Month, Day, Year) State 0 2012 Registrar

DHMH 17 Rev 06-2011

ADDA A CARP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOURI 1001L 2012 NOV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY MEDSTAR MONTGOMERY HOSPITAL OLNEY Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Hours 213-54-6379 Director 90 1 X M 2 □ F May 28, 1922 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Director notified Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ian "natural", or items 23a o Medical Examiner must be Funeral 14639 Bauer Drive, Apt. 314 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married filed within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working r than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Shoemaker Shoes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be filed I Health and Mental Hitem 27 is marked of other traumatic ever ပ Shelmon Nouri Penny Not Available 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle N. Smith (Daughter) 17101 Briardale Road, Derwood, Maryland 20855 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, grematory or other place)
Parklawn
Memorial Park 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State November Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21, 2012 DeVol Funeral Home, Signature of Funeral Serv 22. Name and Address of Facility M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Physician/ Empyemo

Due to (or as a consequence disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequent COPd the burial-part and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 4 Pregnant
9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown မ Medical Certificate:

Division of Vital Records, To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director: After the

1				·			
			24a. Was an autopsy performed? 1 □ Yes 2 → No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No			
25. Was case referred to medical	26. Place of Death (Check only one)						
examiner? 1 ☐ Yes 2 No	Hospital: 1	OA Other: 4 I Nursing Ho	ome 5 Residence 6	Other (Specify)			
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury M		28d. Describe how injury	occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
(Check 2 Medical Examine	cian: To the best of my knowledge, death occurred at ner: On the basis of examination and/or investigation, in r	my opinion, death occurred at	t the time, date and place,	and due to the cause(s) and manner stated			

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3. Time of Death

9. Birthplace (State or Foreign

White

Interval Between
Onset and Death

Day

29d. Date signed (Month, Day, Year)

MD

olney

Nov, 19, 2012

20832

2 weeks

10d. Inside City Limits

1 Yes 2 X No

Russia

10:30 AM

State Registrar

29b. Signature and title of certifie

N. Anantha kinae

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Prince philip drive, Anantha Nuthalapati 18101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November  $^{\text{Day}}$ 7, 20128:00 A M Alexis Thomas Norton Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hyattsville Sacred Heart Home 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 064-20-5331 1 ₺ M 2 🗆 F 86 March 3, 1926 New York Usual Residence of Deceden Show with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 1733 Metzerott Road USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? World

1 X Yes 2 No War II Black, White, etc. 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Religious Brother Hygier other Clergy Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any Injury or other traumatic eveni 18. Mother's Name (First, Middle, Maiden Surname) James Norton Mary Rabbitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Religious S.T. Edwin Dill. Supervisor 733 Metzerott Road, Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 DxBurial 2 Cremation 3 X Removal from State November Joseph Cemetery 4 Donation 5 Other (Specify) Ft. Mitchell, AL Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home, Inc. Mit 500 University Blvd., W., Silver Spring. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Hypertensive Cardiovascular Disease Medical Due to (or as a consequence of): Examiner Coronary Atherosclerotic Disease Sequentially list conditions. Examine any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) the attending physician and the for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: . If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death Month Day 1 Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Progressive Cognitive Decline cate has been sig ; page 2 should b 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 反 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Yes 2 XNo 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) +1 D0051122 November 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1160 Varnum Stree NE, #008, Washington, DC 20017 Juanitez, Esmerando 0. 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

Registrar

NOV 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20<sup>rear</sup> 5:28 November Jean Beverly Nielsen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 168-20-7794 1 □ M 2 🖾 F 85 12/19/1926 Pennsylvania Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20851 1409 Bernerd Place United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 K Widowed 4 □ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Francis P. Hoberg Catherine B. Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Robert G. Nielsen/Son 19009 Festival Drive, Boyds, MD 20841 ortent: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/24/2012 Alexandria, VA Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home Mª Millian Kijan MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): Infarctions disease or condition 1045 Medical resulting in death) Examiner gestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury rsician and burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 🗆 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Tho ပ္ 1 Propatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death account at the cause (s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.O.

Records,

Division of Vital

Rockville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40483 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Vear Dorothy Louise Nies Medical November 20.12 11:30 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cumberland Allegany 217 Union Street, Apt 4 . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 220-30-8036 (Month, Day, Year) 10/01/1929 Country) Marvland **Director** 1 M 2 X F 83 show 10a. State 10b. County with the Maryland items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cumberland Allegany 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1534C E. Oldtown Road 21502 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner Armed Force: Black, White, etc. ō þ 1 X Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White "natural" Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nies pe Louis Howard Bernice Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Floute Number, City or Town, State, Zip Code) 217 Union Street, Apt 4, Cumberland, MD 21502 Department of Health an Important: If item 27 is any injury or other transone. Yvonne Louise Rose-Norris/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 11/29/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Si nature, f Funeral Ser 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD Part 1. Enter the disease or complications that caused shock, or neart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiopulmonary Failure Medical Due to (or as a consequence of Examiner Hypertension Sequentially list conditions, if any leading to immedicause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examir Coronary Artery Disease attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Diabetes Mellitus Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the a d be detached i P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page performe certificate 2 🗌 No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Nother (Specify) Residence Other: 2 🗓 No ျ 1 Tes 1 🗌 Inpatient 2 🗍 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury accurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 X Natural 5 Pending 1 Yes Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier Medical Examiner: On the bag Certifying Nurse Practitioner (Check nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29d. Date signed (Month, Day, Year) R087737 November 27, 2012 2

Registrar
DHMH 17 Rev 06-2011

State

MLS

CRNP,

Bostaph,

31. Date filed (1975) 2012

600

32. Registrar's

death (Item 23a) (Type Print) Memorial Avenue, Cumberland, MD

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40484 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov Physician/ NIEME 1041 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number 217-42-2730 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 27, 1945 Director 1 □ M 2 💢 F Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar mast be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Worcester Berlin 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 United States 10 Fairway Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give 3 XWidowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John White Lorraine Wesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11723 Janney Court Clarksville, Maryland 21029 Donna Frederick -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Pauls Luth. Ch. Cemetery 12/3/2012 4 ☐ Donation 5 ☐ Other (Specify) Fulton, Maryland 21. Signature of Funeral Service Licensee Bollara Vie Bolgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or correctations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Exami To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the bunel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic gregnancy in the past 12 months? 5 Other (specify) Month Dav g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 NO 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nov 29 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Samit Prakash Desai, M.D. HoCoGH 5755 Cedar Lane Columbia, Maryland 21044 10 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40485 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day 2012 Year Month Sophie Onufrak Nov. 5:40 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery Hospice- Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Director 1 □ M 2 🖺 F 81 184-24-6960 Aug. 8, 1931 PA if Heelth and Mental Hygiene. Item 27 is merked other then "neturel", or items 23e or 28a-f show other treumetic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours efter death with the Maryland Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3493 S. Leisure World Blvd 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Specify White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 end 2 should be file Department of Heeith end Mental I Importent: If Item 27 Is merked o eny tijury or other treumetic eve eny tijury or other treumetic eve Gregory Lashick 2 Eva Wasko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary A. Onufrak / Son 1401 S. Edgewood Street, #500, Arlington, VA 22204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Nov. 20 2012 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Spedify) Silver Spring, MD 21. Signature of Funeral Service Dicen Francis J. Collins Funeral Home yehand laters 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buritatings. resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 3 Other (S Hospital: Hospice Facility 잍 1 ☐ Yes 2x No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Anatural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D63195 Nov. 18, 2012 in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Wilks, MD 1355 Piccard Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 0 2012 Registrar

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40486 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Pamela Jeanne Osborne November 5:26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 214-72-2631 1 □ M 2 🕅 F 55 05/10/1957 Washington, DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 13125 Rousby Hall Road 20657 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. by I 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ¥ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) / Benefits Coordinator US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Breed Virginia Jeanne Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Robert Osborne / Spouse 13125 Rousby Hall Road, Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/21/2012 Alexandria, Virginia Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, Maryland 20657 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lit Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ per (a pala disease or condition resulting in death) K r.C Medical Due to (or as a consequence of) **Examiner** ylars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence on Exami burial-transit morbid and that initiated events Due to (or as a consequence of): resulting in death) Last ng physician as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) signed by the atter in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death 1 ☐ Yes 2 № 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed?

1 Yes 2 No 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 ☑ No ျင 1 Inpatient 2 ER/Outpatient 3 POOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death. 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral D Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 0 29d. Date signed (Month, Day, Year) 046314

DHMH 17 Rev 06-2011

State

Registrar

drw

110 Hospital Road, Suite 310, Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registra

Pomilla

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PaulV

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 40487 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 21:09 L. PRESSLEY MAXINE 11 --2012Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PG COMMUNITY HOSPITAL CHEVERLY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) Director 578-54-5647 1 □ M 2 T F Yrs 10-29-1940 DC 72 ıtal Hygiene. ed other than "naturai", or items 23a or 28a-f sho event, <u>the Medical Examiner must be notified at</u>. 10b. County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No CAPITOL HEIGHTS MD PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 US 302 QUARRY AVENUE 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 ☐ Married Completed by within 72 hours after 1 ☐ Yes 2 😾 No Specify: Specify: BLACK 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) FEDERAL GOVERNMENT EEO ASSISTANT n and Mental Hygier e 1 and 2 should be filed w to f Health and Mental Hygi If item 27 is marked other or other traumatic event, is Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 HARRY PRESSLEY SR. FLORA SINGLETARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 QUARRY AVENUE, CAPITOL HEIGHTS, MD 20743 DENISE PRESSLEY/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place, 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 11-29-12 SUITLAND, MD 4 Donation 5 Other (Specify) LINCOLN CEMETERY 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Licensee M00981 Charles 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 🕱 No ဥ 1 Yes 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 6017 30. Name and address of person wito completed cause of death (Item 23a) (Type, Print)

State

Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	State of Mary				nd N			2016	4048	8	
		1 - State RegistrarAmend #4  1. Decedent's Name (First, Middle, La	Per FH JM	11/29/F	izicaie	OI Deatii		2. Date of De			3. Time of Death		
Physicia Medic			kney-Toon					Month November	26, Z	2012 Year	11:357	₩_	
Examin	er	4a. Facility Name (if not institution, giv				own, or Location of	Death			. County of Dea	_		
Funeral		334 Brightseat Road 5. Social Security Number 6.		yrs. last birthday)	If Under	ndover 1 Year   If Under 2	4 Hrs.	8. Date of Birt		Prince G	thplace (State or Forei	ian	
Director		<del>227</del> -34-1308	1 □ M 2 <b>X</b> F	77 Yrs.	Months	Days Hours	Min.	(Month, Da 8–23–19		Co	untry) vland		
nd ihow at	ក	Usual Residence of Decedent  10a. State  10b. County	100	City, Town or Lo	cation			0 23 13		11202	10d. Inside City Limi	its	
Maryla 28a-f s stified	Director	Mid Prince G	eorge's	Landove	r						1 🏿 Yes 2 □	No	
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	alDi	10e. Street and Number	3		10f. Zip					tizen of What Co	ountry?		
ath wi	Funeral	334 Brightseat Road	12. Was Decedent Ever in	n U.S. 13.1		20785 ent of Hispanic Origin	n? (Spe	cify Yes or No-	USA	14. Race - Ame	rican Indian		
ter de	by	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 🔀 No		f Yes, speci	y Cuban, Mexican,	Puerto	Rican, etc.)		Black, Whit	e, etc.		
ours al	eted	3 Widowed 4 Divorced  15. Decedent's	If Yes, Give Year or Dates.			No Specify:					adk		
an "na Medic	Completed	(Specify only highest g		(Give		Occupation done during most or retired)	of worki	ng	16b. K	ind of Business	/Industry		
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nd Me		Charles W Curtis  19a. Informant's Name/Relationship (	Type, Print)	19b. Mailii	na Address	Street and Number		Swann I Route Numbe	r. Citv or	Town, State, Zi	n Code)		
nd 2 st salth a n 27 is er trau		Patrick L Toon, Husba	and			eat Road Lar					,		
ge 1 ar t of He If item or oth		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 [		Ob. Place of Dispo cemetery, crer				Date	20c. Lo	ocation - City or	Town, State		
nit. Pag artmen ortant: injury		4 Donation 5 Other (Spec 21. Signature of June al Service Licer	ify) C	heltenham		y 12 Address of Facility	2–3–2			enham Mar Irll Funer			
permi Depar Impor any ir once.		21. Signature by unleader violatice	INS.			delegant La			_		ar nuie		
		23a. Part 1. Enter the disease, or shock, or heart failure. List only	nplications that caused the one cause on each line.	<del></del>							Approximate Interval Between		
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Examiner		resulting in deathy	Due to (or as a con	sequence of):									
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):										
ecuted and Il-transit	xaminer	Cause (Disease or injury that initiated events											
cate be exe physician a the burial.	ш	resulting in death) Last	sequence of):										
death certificate be ex ne attending physician ed for use as the buria	Physician/Medical	IS SELVALE	d										
eath certifica attending p I for use as t	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	Fetal death 3	Ectopic p					23d. Date of de	,		
the at	ıysic	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	e of death 5 L	Other (spe	ecify)				Month	Day Year		
Physician: The law requires that the de, this certificate has been signed by the . rral director, page 2 should be detached	by Pr	Part II. Other significant conditions	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?			
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ysician: is certific director,	To Be	examiner?  1 \( \sum \) Yes 2 \( \bar{X} \) No	Hospital:	2 ER/Outpatier	at 3 🗀 DO	26. Place of Death Other:			dence 6	Other (Spec	sifu)	_	
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lor At after d Direc d in by		4  Homicide determined			et, factory,	office		28f. Location (S City or Tow			ral Route Number,		
To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral	Medical		ysician: To the best of my k									atad	
the Hithin 24 thin 24 the Fu	Med	only one) 3 K Certifying Nu	niner: On the basis of examin rse Practitioner: To the bes		death occu	red at the time, date		ce, and due to t	he cause	(s) and manner a	s stated.	ated	
o o o wit		29b. Signature and title of certifier	Ma /	CRILL	2	License number 57293				te signed <i>(Mont</i> i <b>27–2012</b>	h, Day, Year)		
Jsm		30. Name and address of person who	completed cause of death	(Item 23a) (Type, F									
~ 31/V		Marren Mayhew RNP	1801 McCommick I	Orive Larg	o Maryl	and 20774						_	
Stat Registra		31. Date filed (Month, Day Year) 201	2 32. Registrar's Si	ign ture	Kel								

DHMH 17 Rev 06-2011

		State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and	Mental Hyg	_	40489	
Physicia Medic		1. Decedent's Name (First, Middle, Last)  ELLIS E. PARSONS	V 1	2. Date of Death	1	3. Time of Death 9:00 AM	
Examin		4a. Facility Name (if not institution, give street and number) 9810 AMBLER LANE	4b. City, Town, or Location of Deat UPPER MARLBORC		4c. County of Death PRINCE GEO	ORGE'S	
Funeral Director		5. Social Security Number 6. Sex 1 $\frac{7}{X}$ M 2 $\frac{7}{7}$ F 77 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birth Court 35 WASH	place (State or Foreign	
yland -f show ed at	ctor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Lo				10d. Inside City Limits	
h the Mai a or 28a be notifi	Funeral Director	MD PRINCE GEORGE'S UPPER MAI  10e. Street and Number	10f. Zip Code	1	0g, Citizen of What Cour	1 √ Yes 2 □ No	
ath wit ms 23 must	uner	9810 AMBLER LANE  11. Marital Status 12. Was Decedent Ever in U.S. 13. V	20772	pacify Vas or No-	U.S.A.	an Indian	
s after or al", or Examin	ρ	1 Never Married 2 N Married 1 N Kes 2 No	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	to Rican, etc.)	14. Race - Americ Black, White, Specify: BL		
72 hou "natu ledical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo	rking	16b. Kind of Business In	dustry	
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pernit. Page 1 and 2 should be filed within 72 hours. Dependent of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.	To Be	17. Father's Name (First, Middle, Last) GAY PARSONS		me (First, Middle, M PARSON	laiden Surname)		
nd 2 shoul ealth and n 27 is m		19a. Informant's Name/Relationship (Type, Print) SHIRLEY C. PARSONS—WIFE 19b. Mailin 9810	ng Address (Street and Number or Ro AMBLER LANE UI	PPER MARL	City or Town, State, Zip (BORO, MD 20	Code) 772	
Page 1 ar ment of Hi ant: If iter ury or oth	1-	4 E Bollation 6 E Gillot (Opposity)	NS CEMETERY 12-	4-2012	20c. Location - City or To CHELTENHAM,	MD	
pernit. Depart Import any inj once.			2. Name and Address of Facility P. 24 - 8TH STREET,		PANGLER F. ASH., DC 20		
Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. In not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  FATAL CARDIAC ARRIDATED TO THE CARDIAC ARRIVATED TO THE CARDI		c or respiratory arre	st,	Approximate Interval Between Onset and Death	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medi		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year	
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tal or Atters as after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)				Route Number,	
he Hospi in 24 hour he Funer ipleted fill	Medical	29a. Certifier (Check only one) 1 ∑ Certifying Physician: To the best of my knowledge, death of the configuration	tigation, in my opinion, death occurred	at the time, date and	d place, and due to the ca	use(s) and manner stated.	
To t To t		29b. Signature and title of certifler	29c. License number		9d. Date signed (Month,	Day, Year)	
ign is		30. Name and address of person who completed cause of death (Item 23a) (Type, F			11-26-2012		
Stat	е	CIELITO AGUINALDO 1221 MERCANTILE I 31. Date filed (Month, Day, Year) 2012 32. Registrar's Significance (Month) 2012 32. Registrar's Significance (Month) 2012 33. Date filed (Month) 2012 33. Date filed (Month) 2012 33. Date filed (Month) 2012 34. Date fi		0774			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 - 2012 Month Everette Alphonso Pratt Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice ialis bur MICOMICO If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Min **Director** 241-94-<u>0634</u> 1 □XM 2 □ F Usual Residence of Decedent 3-16-1955 iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🗶 No Wicomico MD Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 442 Bailey Lane 21801 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural". Completed 3 XWidowed 4 Divorced Spe@Nlack Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Production Worker Poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie T. Pratt Tommie Lee Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is 512 Collins St. Salisbury, MD 21801 Charlene Fontaine/Daughter 20b. Place of Disposition (Name of cemetery, crematory or othe page) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cremation, 11-26-2012 Dover, DE 2 Name and Address of Facility 917 W. Isabella St. 22. Name and Address of Facility 917 Bennie Smith Signature of Funeral Service Licenses Salisbury, Home Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Due to (or as a consequence of): nding physician ause as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: Hospice 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Junavole Sheekan H68413 and address of person who completed cause of death (Item 23a) (Type, Print)

Lunaroll - Sheehan DO PO Box 1733 Sollsbury MD 21802 31. Date

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pitzer Physician/ VIANO Medical 4a. Facility Name (if not institution, give street and number TING JOHNS + TOPKINS + Examiner 4b. City, Town, or Location of Death HOSPITAL saltimor Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Director 46 578-68-7843 1 □ M 2 🗓 F Usual Residence of Decedent 04/23/1966 WASHINGTON, DC 28a-f sho filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No NONE WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5425 Macomb St NW 20016 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian Black. White, etc. \$ 1 Never Married 2 XMarried 3altimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify: Completed 3 Divorced 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education other traumatic event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be James H. Lemon Jr Lavinia F Plumley permit. Page 1 and 2 should Department of Health and M Important: If item 27 is ma any Injury or other trauma? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Andrew C. Pitzer / Husband</u> <u>Macomb St NW Washington</u> DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Creek Cemetery :11/20/12 Washington DC 22. Name and Address of Facility Joseph Gawler's Sons Signature of Funeral Service Licensee 5130 Wisconsin Ave NW Washington DC 20016 M00063 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner domain Drum OSIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial and the completely filled in by the funeral director, page 2 should be detached for use as the burial and the complete of the compl Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 Unknown 2 🗌 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 Yo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မြ 1 Tes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
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Contr 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) leans St. Baltimore, MD 21287 PAVINDRA 31. Date filed (Month, Day, Year) State 32/Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 40492 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PEYNOLD PROSPER

4a. Facility Name (if not institution, give street and number) Medical /19/2012 9:57 а Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital
Social Security Number 6. Sex 7. Age (In yrs. Rockville Montgamery **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 580-09-0240 Director **№** M 2 🗆 F 6/27/1941 West Indies 71 Usual Residence of Decedent an "naturai", or items 23a or 28a-f shov Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 ☐XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 130 Duvall Lane, #304 20877 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Š Yes 2 No Yes, Give end 2 should be filed within 72 hours efter Health and Mental Hygiene, tem 27 is marked other than "naturai", or チアのシア タンプ アンドカップの Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Divorced 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highes grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secon condary (0-12) College (1-4 or 5+) 27 is marked other the traumatic event, the Porter/Salesman Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cecil Isabella Attidore Burton Joseph Prosper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 Department of Heath Important: If Item 27 any Injury or other tr once. 130 Duvall Lane, #304, Gaithersburg, MD 20877 Patricia Prosper /wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 
Burial 2 Cremation 3 
Removal from State 4 Donation 5 Other (Specify) Cremation Ctr. of Md 11/21/2012 Hanover, MD 21. Signat of Funeral Service Acensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) 10 n Medical Due to (or as a consequence of) <sup>'</sup>Examiner Sequentially list conditions, if one leading to impediate cause. Enter Underlying Cause (Disease or injury Examine Due to fores a consequence of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit. To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

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9 Unknown 5 Other (specify) Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 Tes 2 **N**0 Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 ☐ Yes 2 ☐ No. 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title 30. Name and addre son who completed cause of death (Item 23a) (Type, Print) MD 9901 medical Cotr Ar Rockville, mD 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ PARKER RATMOND 06:55 am 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Memorial Hospital Calvert Prince Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Director 214-28-7525 1 **X** M 2 □ F 83 11/15/1929 Maryland Usual Residence of Deceden 28a-f show 10a. State 10b County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits r items 23a or 25a . ....ust be notified a' 1 ☐ Yes 2 🔀 No MD Calvert Huntingtown 10e. Street and Numbe 10g. Citizen of What Country? Funeral 2522 Holland Cliff Road 20639 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. o. ģ 1 Never Married 2 X Married Yes 2 No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" 3 Widowed 4 Divorced Specify: Completed white Year or Dates.1955-57 permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) farmer agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymond Derov Parker Mollie Mollie Elizabeth 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ada M. Parker, spouse 2522 Holland Cliff Road, Huntingtown, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 11/28/2012 Cheltenham, MD Sign Pire of Funeral Service Licer 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 71 year disease Sequentially list conditions Examiner if any, leading to immediate cause. En en Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sinned by the attending humanian and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year Pregnant at time of death 2 No be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by fibrilation 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an HTN page 2 autopsy death? 1 Yes 2 No 2 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: a No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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Nimit A. Shah, M.D., 100 Hospital Road, Prince Frederick, MD 20678

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SHAH, MD

Registra s Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MShoh

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40494 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MNov 25, 2012 Year 1:15 AM<sub>M</sub> Pague Evelyn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Egle Nursing Home Lonaconing If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 217-10-1523 93 Mar 23: 4919 Director 1 □ M 2 ☐ F or 28a-f show 10b. Cour 10c. City, Town or Location 10d. Inside City Limits be notified at Director MD Allegany Lonaconing 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral Egle Nursing Home 21539 USA within 72 hours after death with Examiner must , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces

1 ☐ Yes 2 ☐ No
If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white "natural", 3 → Widowed 4 □ Divorced Completed Year or Dates and Mental Hygiene.
I is marked other than "natur.
raumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Jet Assembler traumatic event, the Celanese Be 18. Mother's Name (First, Middle, Maiden Sumame) Edna Adams 17. Father's Name (First, Middle, Last) ည Harvey Lester Holler 19a. Informant's Name/Relationship (Type, Print)
Carol Lantz 19b. Mailing Address Strept and Number or Rural Route Namber City of Town, State, Zip Code 26753 daughter permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition

1 Durial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Saint Wary's Centerery 11/28/20 Cumberland MD ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Licenses 22. Name ar Seampellif Farmeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. ter ttile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock o heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or or ndition resulting in death) Onset and Death Physician) ALZHEIMER Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal Gea
Pregnant at time of death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No ξ Day Month Year 1 Yes 2 9 Unknown detached the á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed certificate Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes Other: 2 **50** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of s after death. Il Director; After t 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 Tes Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours after To the Funeral Direct Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the Fune completely f To the 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D26907

Registrar

DHMH 17 Rev 06-2011

State

25 Bishop Walsh RD Cumberland MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

***********	Ex	amine	
Division of Vital Records, P.O. Box 68760	e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.	e Funeral Director: After this certificate has been signed by the attending physician and pleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	

Physician/

Medical

**Examiner** 

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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Funeral

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

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Medical

Examine

Physician/Medical

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d, per MD G942 8/13/13 TRT

State of Maryland / Department of Health and Mental Hygien 2 1 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Winifred Ross-O'Cummings November 23, 3:25P 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 618 Cook Drive Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F 87 Yrs. Director 120-16-5270 September 11,1925 New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f ehow Gloul Expression must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Wiamia Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filad within 72 hours aftar death v Department of Haalth and Mental Hygiana. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Mudical Exercises 2006. 618 Cook Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 New York DMV Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Jabez Ebenezer Boatswaine Eugenie Carollapa Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Cook Drive - Salisbury, Maryland 21801 Phillip Ross / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Memorial Park Dec. 8, 2012 Salisbury. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 Clo 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (от аз а солзециелсе of). Hypertenois daath certificata be axecuted burial-transit muna Due to (or as a consequence of): Physician/Medicai usa as tha Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ξ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) datachad o Tha law raquires that tha 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown paga 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? cartificata has autopsy performed? 2 No Vital 2 No 1 Yes Physicien: diractor, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No ð this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attar or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tillad in by 4 | Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31546 November 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 ahus Di Na Mo . 31. Date filed (Month Pay 28') 2012 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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			State Registrar			Certificat	te of Dea	ath		eg. No 2	12	40491
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No.	Examin	er	· ·		Contor		lney _	alion of Death		1	gomer	,
	Funeral		Medstar Montgom 5. Social Security Number	6. Sex 7. Age	(In yrs. last b		er 1 Year If	Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day,			ace (State or Foreign
	Director		194-18-5967	1 □ M 2 🖔 F	89	Yrs.	Days   n	ours Will.	oct. 9,	1923	Penn	sylvania
	nd now at	'n	Usual Residence of Decedent  10a. State  10b. County		10c. City, To	wn or Location					10	0d. Inside City Limits
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	or 28	Ξ	10e. Street and Number	3-13			p Code			10g. Citizen of		
	s 23a	Funeral Director	14508 Homecrest	t Road			209	06		United	State	es
	death r item ner n		11. Marital Status	12. Was Decedent En Armed Forces?		13. Was Dece If Yes, spe	dent of Hispar cify Cuban, M	nic Origin? (Spe Iexican, Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
36	al", o	d by	1 ☐ Never Married 2 ☐ Marri 3 🕅 Widowed 4 ☐ Divorced	If Von City	No	1 🗆 Yes	2 No S	pecify:		Specify	whi	te
Ö	within 72 hours after death with the Maryland grene. ier than "natural", or items 23a or 28a-f sho ; the Medical Examiner must be notified at	Completed		ent's Education est grade completed)	16	6a. Decedent's Usi (Give kind of we	ual Occupation	n most of work	ina	16b. Kind of B	usiness/Ind	ustry
21	nin 72 ne. <b>than</b> "	om	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	life. DO NOT us Secretar	se retired)	g mode of morn	,,,,	Sch	00]	
2	Hygier Hygier Ither	Be C	17. Father's Name (First, Middle, L	last)		Jeci e cai		Mother's Nam	e (First, Middle, f			
au(	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "hadral Examiner must be notified at matic event, the Medical Examiner	Tol	Louis Kanthe	,				Bessie	e (First, Middle, f Eisens	tein		
Maryland 21215-0036	1 and 2 should be if Health and Men item 27 is marke other traumatic	8 8	19a. Informant's Name/Relationsh	hip (Type, Print)		9b. Mailing Addres						ode)
	nd 2 s ealth m 27		Dr. Mark J. Rai	ivetz, Son		L506 Knox		-				
Baltimore,	ge 1 a it of H if ite or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation	3 X Removal from State	ceme	e of Disposition (Na etery, crematory or	other place)		Date	20c. Location	-	1
Ħ	permit. Page 1 Department of Important: If i any injury or once.		4 Donation 5 Other (S		Mt.	_ebanon (	<u>cemeter</u>	y   11/2	20/12 <u> </u>	Collin	gaare	, DE
Ba	permit. Departr Importa any inju			1	10100	254 Ca	rnsky n rroll	St., NW	I, Washi	ngton,	DC 2	0012
Н			23a. Part Phter the disease, or shock, or heart failure. List of	r complications that caused	the death. D							Approximate Interval Between
- V	Pnysician/	8 1	Immediate Cause (Final disease or condition	, ba	cter	nia						Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	consequenc	hic heal	~ C h	este con				
		ř	Sequentially list conditions,	b. Due to jor as a			102 /10	cue cu			-	
	of a steed	Examiner										
	be executed sician and burial-t											
09	ate be exe ohysician the burial	Physician/Medical		d								
687	ertific ding p	/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome of		_				23d. Da	ate of delive	erv
Box 6876	eath c atten	iciai	in the past 12 months?  1  Yes 2 No	4 Pregnant at		eath 3 Ectopic h 5 Other (s						Day Year
В	the d by the tacher	hys	9 🗌 Unknown	9 Unknown					1			
, P.O.	ss that igned be de	þ	Part II. Other significant condition	ons contributing to death bi	ut not resultir	ig in the underlying	g cause given i	in Part I.				e cause of death? pably 4 <b>U</b> nknown
Sp	require	etec							24a. Was a			psy findings available
600	e law e has b	Completed						<	autop perfo	sy med?	prior to cor death?	mpletion of cause of
<u>~</u>	an: Th tificate tor, pa	Be Co	25. Was case referred to medical		_		26. Place	of Death (Chec	1  Yes	2 Mol	1 Yes	2 LJ NO
Zį:	nysicia lis cer direc	년 B	examiner? 1  Yes 2  No	Hospital:	ent 2 🗆 ER/	'Outpatient 3 ☐ I	Other:	4  Nursing He	ome 5 🗆 Resid	ence 6 🗆 Oth	ner (Specify)	
o	ng Ph fter th uneral		27. Manner of Death  1 Natural 5 Pendir	28a. Date of injur (Month, Day		o. Time of injury	28c. Injury at work?		28d. Describe h	ow injury occur	red	
ion	ttendi death ttor: A / the f	Certificate:	2 Accident Investi 3 Suicide 6 Could	tigation d not be	n/ - At home	, farm, street, facto		2 □ No	28f, Location (S	treet and Numb	per or Rural	Route Number
Division of Vital Records,	after after Direct d in by		4 ∐ Homicide determ	building, etc		, rarri, biroot, raote	.,,		City or Tow			
۲	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying (Check 2 Medical I	g Physician: To the best of Examiner: On the basis of ex	my knowledg	ge, death occurred	at the time, da	ate and place, a	ind due to the ca	use(s) and man	ner as state	ed. use(s) and manner stated.
	the H thin 24 the F mplete	Me	only one) 3 Certifying 29b. Signature and title of certifie	g Nurse Practitioner: To the	best of my k	nowledge, death or	curred at the to	ime, date and pl	ace, and due to ti	ne cause(s) and 29d. Date signe	manner as s	tated.
	្ទទទ		230. Signature and title of certifie	m D				4516		11/19/		russ russ
			30. Name and address of person	who completed cause of de								· · · · · · · · · · · · · · · · · · ·
				Prece, mi	> 181	.01 Princ	e Phil	ip Driv	e, Olney	y, MD	20832	
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 20	2012 3. Registra	r's Signature	parked						
			MILLY & U	EUTE KANNERSTON	- 1	4.4						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland	-			Mental Hyg	giene	2	40498
Registrar Certificate of Death							_	neg. No.			
	Physicia		Judith Helene Robe				er 20, 2012 3. Time of Death				
	Medio Examin		4a. Facility Name (if not institution, give st #5 Thorburn Place	reet and number)		4b. City, Town, or Location of Death Gaithersburg			4c. County of Death Montgomery		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthpl Countr	ace (State or Foreign
	Director s		177-38-5155 Usual Residence of Decedent	IM 2 🗓 67	Yrs.			Nov. 4,			ylvania
	ryland -f sho ied at	ctor	10a. State 10b. County  Maryland Montgome:		Town or Loc .thersl					10	d. Inside City Limits
	he Ma or 28a e notif	Director	Maryland Montgome:  10e. Street and Number	Ly Gai	Lileisi	10f. Zip Code			10g. Citizen of Wh	nat Count	1 X Yes 2 □ No
	s 23a nust b	Funeral	#5 Thorburn Place			208	79		United		*
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates.	lf	as Decedent of His Yes, specify Cubar	n, Mexican, Puerto	oecify Yes or No- `o Rican, etc.)	14. Race Black,	America White, et	tc.
15-0	72 hou "natu edical	Completed	15. Decedent's Edu (Specify only highest grad		(Give k	ent's Usual Occupa ind of work done d	ition uring most of wor	king	16b. Kind of Bus	iness/Indi	ustry
212	within giene.		Elementary/Secondary (0-12)	College (1-4 or 5+)	Admir	NOT use retired) nistrativ	e Assist	ant	I.B.M.	•	
Baltimore, Maryland 21215-0036	be filed vental Hygred ental Hygred otheric event,	To Be	17. Father's Name (First, Middle, Last)  Edward Munyan				18. Mother's Nar	ne (First, Middle, M	Maiden Surname)		
lary	should and M is mar aumati		19a. Informant's Name/Relationship (Type			Address (Street a	nd Number or Ru	ral Route Number,			
e, N	and 2 Health em 27 ther tr		Raymond Roberts  20a. Method of Disposition	(Spouse)		norburn P	lace Ga				
imor	Page 1 ment of tant: If it		1 ☐ Burial 2 💢 Cremation 3 🕱 R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cer	metery, crem ropo11	ition (Name of atory or other place tan Crem	20	12	20c. Location - C	ria,	
Ball	Depart Import any inj		21. Signature of Funeral Service License	Deus (M0111		Name and Addres  Deast De					, MD 20877
ı			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one	cations that caused the death. cause on each line.	Do not enter	the mode of dying	, such as cardiac	or respiratory arre	est,		Approximate Interval Between
-	Physician! Medical		Immediate Cause (Final disease or condition resulting in death)	ASC	·V	2				1	Onset and Death
	Examiner			Due to (or as a conseque	nce of):						
	p <b>5</b>	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce of):						
	ate be executed shysician and the burial their		Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a conseque	nce of):					+	
09	te be e nysiciar he buri	dical									
687	ertifical ding ph	/Mec	IF FEMALE:	c. If yes, outcome of pregnance	21/						
Box (	the Hospital or Attending Physician; The law requires that the death certificate be executed thin 24 hours after death.  the Funeral Director. After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial the purished for the funeral director.	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	1  Live Birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Mont		y Day Year
s, P.O	ires that t signed b Id be deta	by	Part II. Other significant conditions conf	ributing to death but not resul	ting in the un	derlying cause give	en in Part I.		oacco use contrib		cause of death?
Records,	w requisite special sp	Completed						24a. Was a	n 24b. We	re autops	sy findings available upletion of cause of
Rec	The law cate has	Com						autops perform 1 🗆 Yes	ned? de	ath?	
Vital	sician: The certificate irector, pag	Be (	25. Was case referred to medical examiner?  1 X Yes 2 □ No	espital:		Otho	ce of Death (Chec				
0	ding Phys h. After this funeral d	te: To	27. Manner of Death	1 Inpatient 2 E  28a. Date of injury (Month, Day, Year)	8b. Time of	3 ☐ DOA 28c. Injury	4 □ Nursing H at	ome 5 Reside	ence 6 Other own injury occurred	(Specify)	
lon	ttendin death. Stor: Aft y the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(IVIONIII, Day, Year)	injury	M 1 □	∕es 2 □ No				
Division of	al or At s after o		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Number , State)	or Rural F	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Examine	ian: To the best of my knowled r: On the basis of examination a Practitioner: To the best of my	and/or investig	gation, in my opinior	n, death occurred a	at the time, date an	d place, and due to	the caus	e(s) and manner stated.
	Vith Vith		29b. Signature and title of certifler	er Valmo	DMG	29c. License			9d. Date signed (I		
	,		30. Name and address of person who con	npleted cause of death (Item 2	3a) (Type, Pr	int) 52	y Hau	nkest	2044	7.	~
	Stat	e	31. Date filed (Month, Day, Year)  NOV 2 7 2012	32. Registrar's Signatur		21100	v Spr	1.21	mu	20	904
è	Registra	ar	NOV 2 7 2012	Dermis B.	gan				<del></del>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 40499 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1/17/2012 Frederica Z. Robichek 0:10A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brighton Gardens Friendship Heights Chevy Chase Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min 030 14 5355 Director 93 1 🗆 M 2 🗓 F 07/21/1919 Czech Republic in then "neturel", or Items 23e or 28e-f show the Wedical Examiner must be notified at filed within 72 hours efter death with the Meryland el Hyglene. el Hyglene, a other then "neture!", or Items 23e or 28e-f sho 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 United States 5555 Friendship Blvd. Apt.#435 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Broker Real Estate permit. Page 1 end 2 should be filled w Depertment of Health end Mentel Hyg Important: If Item 27 is merked othe eny Injury or other treumetic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Schifferess <u>lonstance Oppenheimer</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia Esposito/Daughter 8608 Stirrup Ct., Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State National Crematory Falls Church, VA 11/21/2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, LLC CC0379 5130 Wisconsin Ave., NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Congestive Heart Failure years \*Medical Due to (or as a consequence of): Examiner Debility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 6 years Due to (or as a consequence of) e ettending physicien end ed for use as the buriei-trensit To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 brous after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burliet-tjensit Failure To Thrive 6 years that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year Day , after death, I Director: After this certificate hes been signed by the e od in by the funeral director, page 2 should be deteched 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Blindness 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Chronic Depression 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 \ No 1 Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ျာ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes Accident
Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ertiting N only one) r: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d, Date signed (Month, Day, Year)

State Registrar address of person

NOV 26 2012

31. Date filed (Month, Day, Year,

Daniel J. Esposito, MD/5530 Wisconsin Ave., #1400 Chevy Chase, MD

who completed cause of death (Item 23a) (Type, Print)

D23783MD

11/17/2012

20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul Dow Reddy, Sr. November 5:40 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel South River Health & Rehabilitation Edgewater If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 X M 2 □ F Days Hours Min. 08-14-1921 Illinois Director 331-18-2449 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 275 is marked outher than "natural", or items 23a or 28a-f sho ant: If item 275 is marked outher than "natural", or items 23a or 28a-f sho ury or orher traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20754 USA 3462 Yellow Bank Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal and P.G. Co. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Printer Governments Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Dow Reddy Nettie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul D. Reddy, Jr., Son <u>Yellow Bank Road, Dunkirk,</u> MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any injury or Cedar Hill Cemetery 11-26-2012 | Suitland, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. William MO0715 8325 Mt. Harmony Lane, Owings, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Atherosclerotic Physician Cardiovasterian Medical resulting in death) Due to (or as a consequence of) Examiner Cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit Exam The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 🗌 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Airwoys obstructive 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Insufficiency 24a. Was an has autopsy perform Fibrillotion A+81'01 this certificate Yes 2 No 25. Was case referred to medical examiner?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) Physician: completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After the state of the s 1 🖪 Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 50653 11-21-2012 on.c GVAN SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C Church 5851 Deale 20751 Road Deale

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registra s Sig

NOV 2 & 2012